WORKING PAPER / 2011.02

Sector Monitoring and Evaluation Systems in the context of Changing Aid Modalities: The case of Niger's Health Sector

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ABBREVIATIONS

AAA	Accra Agenda for Action
ADPRS	Accelerated Development and Poverty Reduction Strategy
AFD	Agence Francaise de Développement
AMSTAR	A Measurement Tool to Assess Reviews
CASP	Critical Appraisal Skills Programme
CDF	Comprehensive Development Framework
CEN-SAD	Community of Sahel-Saharan States
CNS	Comité National de Santé
CPIA	Country Policy and Institutional Assessment
CTIA	Comité Technique Inter Agences
CTNS	Comité technique National de Santé
DAF	Direction des Affaires Financieres
DEP	Direction des Études et de la Planification
DRSP	Direction Régionale de la Santé Publique
DS	Direction des Statistiques
EC	European Commission
ECOWAS	Economic Community of West African States
FC	Fonds Commun
GAVI	Global Alliance for Vaccines and Immunisation
GDI	Gender-related Development Index
GEM	Gender Empowerment Measure
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GII	Gender Inequality Index
GNI	Gross National Income
HARPS	Health Research Policy and System
HDI	Human Development Index
HIS	Health Information System
HMN	Health Metrics Network
HSS	Health System Strengthening
IDA	International Development Aid
IHP+	International Health Partnership Plus
IMF	International Monetary Fund
INS	Institut National de la Statistique
IRAI	IDA Resource Allocation Index
JSR	Joint Sector Review
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MfDR	Management for Development Results
MSP	Ministère de la Santé Publique
MTEF	Medium Term Expenditure Framework
NGO	Non-Governmental Organisation
ODA	Official Development Aid
ODI	Overseas Development Institute
PARIS21	Partnership in Statistics for Development in the 21st Century
PD	Paris Declaration
PDS	Plan de Développement Sanitaire

PEFA	Public Expenditure and Financial Accountability
PEMFAR	Public Expenditure Management and Financial Accountability Review
PFM	Public Finance Management
PRSP	Poverty Reduction Strategy Paper
PRS/PS	Poverty Reduction Strategy/ Permanent Secretariat
RCT	Randomised Controlled Trial
RPRS	Regional Poverty Reduction Strategy
SBS	Sector Budget Support
SMART	Specific, measurable, achievable, regularly measured and time bound
SNDS	Stratégie Nationale de Développement de la Statistique
SNIS	Système National d'Information Sanitaires
SSA	Sub-Sahara Africa
SWAp	Sector Wide Approach
TFP	Technical and Financial Partner
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
WAEMU	West African Economic and Monetary Union

ABSTRACT

Within the context of the 2005 Paris Declaration (PD) and the 2008 Accra Agenda for Action (AAA) recipient countries have committed themselves to setting up transparent results-oriented reporting and assessment frameworks, while donors are expected to use these frameworks and to collaborate with recipients in order to strengthen recipient countries' systems. However, progress in this area is slow: only three out of 54 countries in the 2008 PD Survey had adequate results-oriented frameworks. Donors, from their side, are reluctant to rely on systems which are only partially developed, which simultaneously blocks the further elaboration and maturing of recipient systems.

Progress at sector level is generally stronger and particularly within health and education sectors where, in the context of Sector Wide Approaches (SWAps), several initiatives have been taken to strengthen monitoring and evaluation (M&E) systems. Prior to strengthening an M&E system it is important to assess the strengths and weaknesses of the existing system, taking both M&E supply and demand sides into account. This working paper analyses the M&E system in the health sector of Niger and focuses on issues of policy, methodology, organisation (structure and linkages), capacity, participation of actors outside government and use of M&E outputs.

The assessment of the M&E system in Niger's health sector shows a mixed picture of a partially developed system. When taking into account that Niger is one of the least developed countries in the world, with very weak scores on many health indicators, this outcome is more positive than expected. The very prominent role of donors might possibly be related to the scores obtained. The authors of this working document, however, argue that if M&E system strengthening is to a large extent pushed from the outside (donors) and not motivated through an internal M&E demand and supply side (both from within as well as outside government), it is likely that the outputs of the system as well as their use will be weak.

1. INTRODUCTION

With the aim to increase aid effectiveness, the 2005 Paris Declaration (PD) sets out a reform agenda for donors and recipients around the core principles of 'ownership', 'alignment', 'harmonisation', 'managing for results' and 'mutual accountability'. Commitments have been reaffirmed through the 2008 Accra Agenda for Action (AAA).

Measurement of progress in the implementation of the PD/AAA is based upon 12 indicators (OECD/DAC, 2005). The indicator for measuring progress in the 'management for results' principle is the "number of countries with transparent and monitorable performance assessment frameworks to assess progress against (a) the national development strategies and (b) sector programmes" (OECD/DAC, 2005: 10). The indicator is composed of three sub-components, i.e. 'stakeholder access to information', 'quality of information' and 'coordinated country-level monitoring and evaluation'. While commitments of donors in the area of 'results-orientation' are not captured in an indicator, donors promised to "link country programming and resources to results and align them with effective partner country performance assessment frameworks, and to refrain from requesting the introduction of performance indicators that are not consistent with partners' national development strategies". Additionally, they committed themselves to "work with partner countries to rely, as far as possible, on partner countries' results-oriented reporting and monitoring frameworks" and to "harmonise their monitoring and reporting requirements, and, until they can rely more extensively on partner countries' statistical, monitoring and evaluation systems, [work] with partner countries to the maximum extent possible on joint formats for periodic reporting" (OECD/DAC, 2005: 8). Moreover, donors and partner countries jointly committed to "work together in a participatory approach to strengthen country capacities and demand for results based management" (OECD/DAC, 2005: 8).

Progress in the implementation of reforms in this area is however slow: the last update of the Comprehensive Development Framework (CDF) report (World Bank, 2007), on which indicator 11 is based, reveals that only three out of 54 countries surveyed had result-oriented frameworks that were deemed adequate (OECD/DAC, 2008a:58-59). While many countries have a number of monitoring and evaluation (M&E) activities and arrangements in place, especially at sector level where progress is generally stronger than at national level (Wood et al., 2008: 22), there is often a lack of coordination between different components of a system. Moreover, M&E outputs, such as performance reports, are frequently incomplete and often include inaccurate data, which affects their utility (Nash et al., 2009). Donors, from their side, are reluctant to rely on systems which are only partially developed. This simultaneously blocks the further elaboration and maturing of recipient systems. In order to escape this persistent chicken-and-egg-dilemma, a pragmatic two-track approach could be a possible way forward. It combines the set-up and/or strengthening of recipient M&E systems (long-term) with complementary M&E activities that fulfill the existing M&E needs in the short and middle run (see Holvoet and Renard, 2007; Holvoet and Inberg, 2009).

For a performance assessment framework to be nationally owned and properly functioning, it is crucial to have an appropriate organisation of a national M&E system with clear division of responsibilities between different levels and layers of government and with clearly identified information streams and accountability structures between central and line ministries and between the local and national level. While strengthening M&E systems does not seem to be a priority of many donors and partner countries, it is obvious that if donors want to make

progress on the 'alignment' and the 'managing for results' principles, more efforts are needed to strengthen and use recipient M&E systems. Strengthening recipient M&E systems generally leads to an improvement of accountability and learning, which may ultimately lead to increased performance and results on the ground. Along the same line, it has been observed that the quality of joint sector reviews (JSRs) largely depends on the quality of the underlying sector M&E system (Holvoet and Inberg, 2009). Strengthening sector M&E systems will contribute to an improvement of the quality of the JSR in the short run and change its outlook over time. In the long run, the JSR can evolve towards a kind of meta-evaluation instrument which monitors and evaluates the existing M&E system (including some reality checks on the ground) instead of being a monitoring and evaluation instrument of activities and outputs.

Prior to the development of an M&E system, it is important to start with an assessment of the quality of existing system or arrangements, taking into account both the M&E supply and demand side. A harmonised M&E diagnostic instrument does not exist so far, but there are some interesting independent and donor-led assessments and studies which may provide inspiration. Examples include the evaluation capacity building diagnostic guide and action framework (Mackay, 1999), the highly similar readiness assessment (Kusek and Rist, 2002), the diagnostic instrument elaborated in Bedi et al. (2006), the checklist used by Booth and Lucas (2002) in their diagnosis of Poverty Reduction Strategy Paper (PRSP) related M&E systems in 21 countries and the checklist used by Holvoet and Renard (2007) in their diagnosis of PRSP M&E of 11 Sub-Sahara Africa (SSA) countries. While these tools are mainly used for the assessment of central M&E systems, they could also guide assessment exercises of sector M&E systems. The scope of a sector diagnosis is obviously more limited but key components and guiding principles of a sector M&E system largely overlap with those of a central M&E system. An important specific issue within a sector diagnosis is the contribution of sector M&E activities to a central M&E system (Mackay, 2007).

This working paper focuses on the M&E system of Niger's health sector. The M&E system is assessed on the basis of the checklist of Holvoet and Renard (2007), which is adapted and extended to make it more suitable to the sector level. The checklist consists of six criteria: i) policy, ii) methodology, iii) organisation (split into iiia: structure, and iiib: linkages), iv) capacity, v) participation of actors outside government and vi) use of M&E outputs. These criteria are further subdivided into 34 questions (see annex 1) and assessed using a five-point scoring system: weak (1), partially satisfactory (2), satisfactory (3), good (4) and excellent (5). The assessment draws upon secondary data, including official documents provided by the government of Niger, academic and grey literature on Niger and health information systems. In a next phase, this desk study will be complemented with field study in order to gain deeper insights in the M&E system of Niger's health sector.

The structure of the paper is as follows: section two presents recent global developments within the health sector (specifically focused on the development of Sector Wide Approaches (SWAps) and on evidence-informed health policy and systems) and section three provides background information on monitoring and evaluation in the health sector and focuses in particular on health information systems and joint sector reviews. Section four briefly introduces the Niger case study and emphasizes issues related to M&E and development aid. Section five concentrates on Niger's health sector and provides information on Niger's progress on some health indicators, the health policy and –strategy, health systems (including the health information system) and health financing. The assessment of the M&E system in Niger's health

sector in section six shows a mixed picture: the M&E system is not yet well developed (no ‘good’ and ‘excellent’ scores), but also not extremely weak (at least on paper), with only one ‘weak’ score for the ‘use of information’ criterion. Two other criteria (methodology and participation of actors outside government) score ‘satisfactory’ and the remaining three criteria (policy, organisation (both structure and linkages), capacity) score ‘partially satisfactory’. Section seven concludes and discusses whether the prominent role of donors might have been conducive to the relatively reasonable scores.

2. GLOBAL DEVELOPMENTS WITHIN THE HEALTH SECTOR

In the past two decades many developing countries introduced health sector reforms, inspired by influential World Bank reports including the *Financing of Health Services in Developing Countries*, an *Agenda for Reform* (Akin et al., 1987), in which the introduction of user fees is stimulated, and the 1993 World Development Report *Investing in Health* (World Bank, 1993), in which five policy priorities are promoted[1] (Atkinson, 2002; Okuonzi and Birungi, 2000). Since the adoption of the Millennium Development Goals (MDGs) in 2000, health sector reforms have been mainly tailored towards the realisation of the health related MDGs in 2015: reduce child mortality (MDG 4), improve maternal health (MDG 5) and combat HIV/AIDS, malaria and other diseases (MDG 6).

Critical comments on the health sector reforms which have been adopted include the narrow focus on structural and management reforms at the expense of health system governance (Siddiqi et al., 2009) and the lack of rigorous evaluation of some widely used reforms which may be ineffective or even harmful. Such reforms include amongst others the adoption of user fees for essential medicines, contracting with the private sector to provide health services as well as some forms of results-based financing (Oxman et al., 2009a) and decentralisation (Atkinson, 2002). Decentralisation increases decision-making at local level and is thus expected to lead to more effective and efficient health care provision. However, according to Atkinson (2002), fully decentralised districts do not necessarily have more capacity, as compared to other districts which are not (fully) decentralised. They neither show higher improvements in health productivity nor better assessments on satisfaction, utilisation and accessibility.

Health system strengthening, which is often a component of health sector reforms, is still underfunded at times when Official Development Aid (ODA) for the health sector has been increasing for several years (World Bank et al., 2008; Working Party on Aid Effectiveness, 2008). Financing for MDG 6 (HIV, TB and malaria) accounts for much of the increase in ODA (World Bank et al., 2008; Piva and Dodd, 2009). However, global programmes, like the Global Funds to fight Aids, Tuberculosis and Malaria (GFATM) (which is partly responsible for the increase in availability of funding for MDG 6) and the Global Alliance for Vaccines and Immunisation (GAVI), which are often blamed for using parallel systems and processes (Biesma et al., 2009), are increasingly investing in health system strengthening and capacity building (Working Party on Aid Effectiveness, 2008; Piva and Dodd, 2009). Moreover, global programmes have been contributing to the institutionalisation of civil society and private sector involvement in the development and implementation of project and programme proposals and have been innovators in their concentration on results-focused performance and monitoring and evaluation (M&E) (see also section 3) (World Bank et al., 2008). Along the same lines, the World Bank, the OECD and the World Health Organisation (WHO) argue in a report which they prepared as input for the 3rd High Level Forum in Accra (2008) that global programmes are

[1] The 1993 World Development Report suggests five priority policies for low-income countries: "providing solid primary schooling for all children, especially girls; investing more resources in highly cost-effective public health activities that can substantially improve the health of the poor; shifting health spending for clinical services from tertiary care facilities to district health infrastructure capable of delivering essential clinical care; reducing waste and inefficiency in government health programs; and encouraging increased community control and financing of essential health care" (World Bank, 1993: 157/158).

adapting more rapidly to the Paris Declaration agenda than several large traditional bilateral donors (World Bank et al., 2008).

While the 1993 World Development Report already urged to improve the effectiveness of aid for health (World Bank, 1993: 167), the 2008 Paris Declaration progress report had to conclude that, at country level, aid for health is still ineffective. The ineffectiveness is manifested by e.g. a poor harmonisation of aid; unpredictable, short-term and volatile aid; the undermining of the leadership role of Ministry of Health due to aid fragmentation and unpredictability; unintended consequences of changes in aid[2] and a difference in aid levels between countries with similar health indicators (Working Party on Aid Effectiveness, 2008: 107/108). The next paragraph will focus on Sector Wide Approaches which were introduced in the nineties partly to address some of these issues, but with only partially successful results. Paragraph 2.2. will focus on evidence-informed health policy and systems.

2.1. Sector Wide Approaches

The concept of Sector Wide Approaches (SWAp) in the health sector was introduced in the nineties as a result of a growing acknowledgement of the limitations of project support (e.g. fragmentation, transaction costs, lack of ownership) and programme aid (e.g. short term, linked to and therefore dependent on macro-economic reforms) (Cassels, 1997) and the belief that progress in health outcomes is not possible without improving health systems (Hutton and Tanner, 2004; IHP+, 2008). SWAps are focused on ownership, as imposed reforms did not have the desired effects (Foster, 2000), on collaboration, as fragmentation of aid undermines effective aid (Buse and Walt, 1996; Foster, 2000) and on the to use of receiving countries' systems for planning, financial management and M&E (Cassels, 1997). In fact SWAps could be seen as an early shift towards more ownership, harmonisation and alignment at sector level, principles which were later generally adopted in the Rome and Paris Declarations (Walford, 2007).

Important elements of a health SWAp are a policy framework which is focused on priorities in the health sector, an expenditure framework which budgets these priorities, an institutional framework (strengthening and using national management systems) and a partnership between government and donors (Peters and Chao, 1998). SWAps are not only changing the relationship between governments and donors, but also the relationship between different parts of government, e.g. between the Ministry of Finance and sector ministries and within the Ministry of Health between senior policy makers and officials responsible for project management (Cassels, 1997).

Before introducing a SWAp in a sector, a country should ideally meet certain conditions. Bodart et al. (2001) formulated 13 enabling factors, on the basis of Cassels (1997) and Harrold and Associates (1995), which they used to assess whether Burkina Faso was ready for a health SWAp. These enabling factors are grouped into three topics, (i)

[2] Unintended consequences include the possible negative impact of the shift to GBS on the health sector in those cases where the Ministry of Finance believes that the health sector already receives sufficient funds through global programmes. Additionally, countries increasingly face limitations to set spending priorities as decision-making is increasingly dominated by global and regional priorities.

macroeconomic conditions, (ii) government capacity and (iii) donors capacity, and are further decomposed into: (i) equilibrated budget and balance of payment; low inflation rate; favourable intersectoral allocation; (ii) strong sectoral ministry; openness to innovation and change; ready for self-criticism through sector analysis; leadership with regards to donors; readiness to collaborate with other stakeholder; (iii) successful donor coordination; existing UN coordination or of EU member States; readiness to support Ministry of Health; prospect for a harmonisation of procedures (procurement, monitoring, evaluation); and prospects for a common financial basket.

While the necessary presence of some of these factors such as openness to innovation and change, readiness to collaborate with other stakeholders and prospects for harmonisation and a common financial basket seems to be reasonable, other factors, such as coordination and capacity are rather expected to be strengthened through a SWAp. According to e.g. Walford (2007) a SWAp should contribute to stronger coordination, harmonisation and alignment and enhance national ownership and domestic accountability, which should all lead to better access to health services and improved health outcomes. Leadership with regards to donors, another of Bodart's et al. (2001) enabling factors, does seem to be an essential precondition for a SWAp's success, as the health SWAp in Uganda demonstrates. While this SWAp was considered a best practice in its earlier years when leadership was still strong, even to the extent that other countries sent delegations to learn from it, lack of government's leadership in more recent years have led to a deterioration of the SWAp's functioning (Ortendahl, 2007).

Walford's 2007 review of six health SWAps in Africa[3] showcases that SWAps have contributed to better coordination, harmonisation and better policy, planning and resource allocation, but not to lower transaction costs. The review does not draw any firm conclusions regarding the impact on health outcomes. It highlights that, even though a SWAp can strengthen systems "it cannot achieve a transformation of public services and sector performance until there is adequate funding, institutional capacity, and suitably trained, motivated and deployed human resources" (Walford, 2007: 18). Additionally, Walford (2007) emphasizes that the impact of SWAps could be increased if more donors would adhere to the SWAp principles. In Zambia for example, the anticipated contribution of the health SWAp to efficient allocation and use of resources was minimal, which according to Chansa et al. (2008) could be related to the fact that the majority of donors who are participating in the health SWAp are still using their own planning, budgeting and reporting formats. The study concludes that in order to achieve a full SWAp all actors in the health sector have to align themselves with sector strategic plans and harmonise implementation and reporting systems. As Chansa et al. (2008: 250) put it, "doing this will not require a modification of the SWAp model itself; it is rather a task of developing systems for planning, funding and monitoring and evaluation which all stakeholders can trust and adhere to".

Several health initiatives, labelled the International Health Partnership Plus (IHP+), build on the lesson from SWAps and aim to strengthen national health systems and to harmonise donor actions at country level. IPH+ bases its actions on five principles: i) one single country health and HIV/AIDS plan; ii) one single policy matrix and results framework; iii) one

[3] Ghana, Malawi, Mozambique, Tanzania, Uganda and Zambia.

single budget; iv) one monitoring framework and process and v) one single country-based validation process (World Bank et al., 2008).

Sector Budget Support

The two most important aid modalities related to SWAps are Sector Budget Support (SBS) and Common Basket Funds (Overseas Development Institute and Mokoro, 2010). SBS could be given in different forms: un-earmarked, broadly or specificilly earmarked to make justification against specific public expenditure, non-traceable or traceable (separately identifiable in the government's budget) (Overseas Development Institute and Mokoro, 2010). Non-financial inputs associated with SBS include policy dialogue, conditionality frameworks and technical assistance and capacity building (Overseas Development Institute and Mokoro, 2010). Capacity building is particularly important, as SBS donors have to rely on the systems of recipient governments which are generally weak. Foster (2000) warns against a rash reliance on government systems as capacity takes time to be built and weak capacity can lead to a decline in disbursement.

In their study on Sector Budget Support, the Overseas Development Institute (ODI) and Mokoro (2010) have highlighted that SBS contributed to the expansion of service delivery while the quality of service delivery has not been effectively addressed (Overseas Development Institute and Mokoro, 2010). A critical shortcoming of SBS is the lack of focus on service delivery, referred to by ODI and Mokoro (2010) as 'missing middle'. Explanatory factors include the specific background of government officials (often finance and economics) and the superficial country knowledge of donor staff participating in the sector dialogue (Overseas Development Institute and Mokoro, 2010). Shortcomings which are specifically related to the SBS dialogue include the narrow focus on details at the expense of overall sector policies and systems, which is often due to the majority of SBS being traceable and earmarked, and the weak link with the dialogue and conditions related to General Budget Support (Overseas Development Institute and Mokoro, 2010).

One of the Paris Declaration's targets for 2010 was that 66% of the aid flows are provided in the context of programme-based approaches (OECD/DAC, 2005). A 2008 study of the World Bank, OECD and WHO concluded that this target will probably not be met in the health sector, as the amount of aid channelled through sector and budget support programmes remains low (World Bank et al., 2008). Notwithstanding this observation, nowadays a mix of modalities is increasingly being promoted (Orthendahl, 2007; Walford, 2007; Overseas Development Institute and Mokoro, 2010), with project aid supplementing budget aid to target e.g. system and capacity strengthening (Overseas Development Institute and Mokoro, 2010) or to promote involvement of civil society (Walford, 2007).

According to Boesen and Dietvorst (2007) SWAps are often too narrowly conceived as an aid-delivery instrument. In their Joint Learning Programme on Sector Wide Approaches, they emphasise that a SWAp should be more encompassing and aim at making the sector development processes effective for poverty reduction. As they put it: "in this wider perspective, the SWAp becomes a domestically owned and driven approach for effective sector development management" (Boesen and Dietvorst, 2007: 15).

2.2. Evidence-informed health policy and systems

While SWAps and the global health programmes contributed to an increasing focus on results and accountability in the health sector (Siddiqi, 2009), health policies are also increasingly informed by evidence. This results from e.g. a closer collaboration between researchers and policy-makers in setting research agendas and the increasing availability of relevant knowledge and capacity to conduct systematic reviews (Hanney and Gonzalez-Block, 2009)[4]. Nevertheless, compared to clinical medicine, the evidence base for health care policy and systems is still relatively weak (Hornby and Perera, 2002; Hanney and Gonzalez-Block, 2009; Lavis et al., 2009a). In fact, much research on health policy and systems is integrated in disease specific research, as a result of which this kind of research is undervalued and fragmented (Ranson and Bennett, 2009). To deal with this undervaluation and fragmentation, the Task Force on Health Systems Research, which was set-up by the WHO in 2003 to develop a research agenda to support the MDGs, have adopted an approach to focus on health policy and system research questions separately from disease specific research questions (Ranson and Bennett, 2009). According to the Task Force on Health System Research, weaknesses within health systems are important obstacles to achieving the MDGs, while there is still much left unknown about health system strengthening and scaling-up of effective interventions. Therefore the Task Force advocates more resources to answer specific health system research questions and to build capacity within less-developed countries (Task Force on Health System Research, 2005).

In 2009, the Health Research Policy and System (HARPS) journal, which was established by the WHO to increase the impact of research on policymaking, published a SUPPORT Tools for evidence-informed health policymaking (Hanney and Gonzalez-Block, 2009) that could be used by policymakers to find and use research evidence (Lavis et al., 2009b). The SUPPORT Tools demonstrate to policymakers amongst others that research evidence can be used to clarify a problem (Lavis et al., 2009c), to frame options to tackle a problem (Lavis et al., 2009a) and to address how a policy option will be implemented (Fretheim et al., 2009a).

While global evidence, which should be based on research prioritised at country level (Ranson and Bennett, 2009), is considered the best starting point for impact assessments of policies and programmes (Oxman et al., 2009b), this evidence should be complemented with local evidence. The latter may be useful in providing information regarding the specific context, the local costs and the availability of resources and may help to set priorities for the development of evidence informed policy and programme options (Lewin et al., 2009a). Local evidence may be acquired from routine health information systems, disaggregated surveys or studies which include data collected or analysed at the local level (Lewin et al., 2009a).

Many organisations which are supporting the use of research evidence make use of systematic reviews (Oxman et al., 2009c), which are considered an important information

[4] Factors which influence the use of research positively include: interaction between researchers and policymakers; good timing and timely research; and policy networks and trust. Factors which influence the use of research negatively include: poor timing or lack of timeliness; negative attitude towards research evidence of policymakers; lack of relevant skills and expertise of policymakers; and a lack of perceived relevance, the use of jargon and the production of publications aimed at a scholarly audience (Oxman et al., 2009).

source on impacts and a tool to frame different options (Lavis et al., 2009d). Compared to single studies, systematic reviews have several advantages for policymakers, including a decreasing risk of being misled, because the methods used in systematic reviews are more systematic and transparent, and an increasing insight in the feasibility of different options as the number of units for study are increased (Lavis et al., 2009d). However, some systematic reviews fail to specify questions, methods and criteria for sample study inclusion and exclusion, to adequately describe the studies selected, to assess the risk of publication bias or to use appropriate methods for combining the results of the different studies included, as a result of which less confidence can be placed in the findings (Lewin et al., 2009b). Therefore, prior to use, the quality of systematic reviews should be assessed, for which several tools have been designed, including AMSTAR (A Measurement Tool to Assess Reviews) and CASP (Critical Appraisal Skills Programme) (Lewin et al., 2009b).

Conditional to the establishment of an evidence-informed health policy and systems and SWAPs in general is a good functioning M&E system. As alluded to in the introduction, M&E systems at central level are often weakly developed in developing countries. The next section more specifically focuses on (the quality of) M&E systems in the health sector.

3. MONITORING AND EVALUATION IN THE HEALTH SECTOR

A monitoring and evaluation (M&E) system within the health sector should provide information on inputs (e.g. funding, plan), processes (e.g. capacity building), outputs (e.g. service delivery, health system), outcomes (e.g. service utilisation, equity) and impact (e.g. child mortality, maternal mortality, morbidity) (IHP+, 2008). While Sector Wide Approaches (SWAps) are supposed to strengthen M&E systems (Hutton and Tanner, 2004), at the same time weaknesses in M&E systems have been identified as a threat to the sustainability of SWAps (World Bank, 2001). The attention for the institutionalisation of an M&E system within the SWAp context is important as, different as project aid, donors are no longer able to attribute their financial inputs to specific outputs, but rather have to justify their individual contributions in terms of progress against jointly agreed sector objectives (Cassels, 1997). The design of an M&E system in SWAp countries is rather difficult, due amongst other factors to the use of different sets of indicators (Peters and Chao, 1998), as a result of which many SWAp countries have weak M&E systems and statistical institutions (Boesen and Dietvorst, 2007). As financial means and activities to attain the health-related MDGs are scaled up, the need to invest in a well-functioning M&E system in the health sector is recognised by diverse health partners (IHP+, 2008; Chan et al., 2010). Recently, eight agencies working in the area of global health[5] committed themselves to reserve funding for M&E system strengthening and to support countries in the development of a coherent M&E plan (Chan et al., 2010)[6]. The agencies adhere to the principles of the IHP+ common framework for monitoring performance and evaluating progress in the scale-up for better health, which is in line with the Paris Declaration and includes: collective action, alignment with country processes, balance between country ownership and independence, harmonised approach to evaluation and performance assessment, capacity building and health information system strengthening and provision of adequate funding (IHP+, 2008).

The IHP+ clearly distinguishes between monitoring and evaluation, unlike many others who use the two terms interchangeably (Fretheim et al., 2009b). Moreover, as Holvoet and Renard (2007) highlight, many developing countries focus in practice more on monitoring ('were the targets met?') than on evaluation ('why were the targets not met?') and therefore underlying reasons for (non-) performance are insufficiently grasped. The IHP+ (2008: 6/7) points to some obstacles which might hamper the successful development and implementation of evaluation efforts, including:

- Evaluations require collective actions and stakeholders do not have enough incentives to invest in evaluation;
- Donor countries and global initiatives feel pressure to demonstrate the attribution of their contribution, while this is of less concern from a country perspective;

[5] World Health Organisation, Global Fund to Fight AIDS, Tuberculosis and Malaria, Global Alliance for Vaccines and Immunisation (GAVI), United Nations Population Fund (UNFPA), Human Development Network, UNAIDS, UNICEF, Global Health Program.

[6] Other commitments made by the eight organisations include "ensuring that global efforts in evaluation are transparent and reproducible at the country level by investing in the development of user-friendly tools, software, and training programs in support of country capacity for analysis and synthesis" and "investing in sound evaluation of the scaling up in a way that adheres to the principles of the common IHP+ evaluation framework, ensuring that independence and scientific rigor are balanced with country ownership and alignment with country processes (Chan et al., 2010: 3).

- Randomised controlled trials (RCTs) are not suitable in the context of broad-based scaling-up of multiple health interventions, while the emphasis put on RCTs has hindered investments in other evaluation methods;
- Large recipients of funding are often worried about possible unfavourable evaluation results. Evaluators are not always independent enough from country or international pressures;
- Inadequate investments are made in baseline data collection, systematic monitoring and health information system strengthening. Too much focus is put on the creation of indicators and reporting requirements;
- Research and evaluation capacity is weak and the recommended reservation of 5-10% of funds to monitoring performance and evaluation is only occasionally met.

Fretheim et al. (2009b) mention some alternatives to RCTs, including two types of quasi-experimental design: i) a controlled before-after evaluation, in which the changes before and after programme implementations are compared to changes in areas where the programme was not implemented, and ii) an interrupted time-series in which data are collected before, during and after the programme implementation. Harpham and Few (2002) suggest using a multi-dimension evaluation in cases where baseline data are missing; even if this kind of evaluation does not provide in-depth information, it can demonstrate the health intervention's contribution to broader development objectives. Moreover, a multi-dimension evaluation can be implemented at relatively low cost.

While SWAps arrangements generally foresee a midterm evaluation and a final evaluation of the health strategy, the focus is often on the monitoring of indicators. Indicators used in SWAps are supposed to be agreed upon by all partners and related to long term strategic goals, their targets should be SMART (specific, measurable, achievable, regularly measured and time bound) and their selection should be decided on before the start of the programme (Brown et al., 2001). As a learning-by-doing approach is incorporated within SWAps, according to Boesen and Dietvorst (2007), SWAp monitoring should serve accountability as well as learning needs. Therefore, different indicators should be selected for accountability and learning objectives: outcome indicators for dialogue and process or output indicators for conditionality (Boesen and Dietvorst, 2007). In practice, however, as the case of the Uganda health sector demonstrates, failures in attaining the targets for conditionality indicators hardly lead to a withdrawal of funds. This is amongst other factors due to the wish not to interrupt long-term trust relationships and health sector performance and the fear of being accused of interfering in domestic affairs (Cruz and McPake, 2010).

Health information systems (HIS) are an essential supplier of data for M&E activities, in particular data related to coverage and utilisation; for impact evaluation other data are needed as well (see e.g. Alliance for Health Policy and System Research, 2007). Because health information systems in developing countries are often not integrated and well-functioning, M&E in Ministries of Health tends to be ad hoc and dependent on demand and resources (Hornby and Perera, 2002). Strengthening sector M&E systems will thus logically entail strengthening of the health information systems. This chapter will further elaborate on health information systems strengthening in section 3.1. Section 3.2. focuses on Joint Sector Reviews (JSRs), a newly created M&E instrument in the SWAp context.

3.1. Health Information Systems

Donors involved in SWAps, but also global health initiatives such as the Global Alliance for Vaccines and Immunisation (GAVI) and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), which use results-based financing mechanisms, increasingly demand health information for accountability and learning purposes (Health Metrics Network, 2008; World Health Organisation, 2009; Chan et al., 2010). However, health information systems (HIS) which are expected to produce this information are often very fragmented due to the involvement of many different institutions in the production and demand of health information and the various requirements of disease-focused programmes (Health Metrics Network, 2008; IHP+, 2008; Kimaro et al., 2008). As a consequence, information is not easily accessible and health workers responsible for data collection are overloaded with reporting demands from several poorly coordinated subsystems (Health Metrics Network, 2008). As these health workers are often inadequately trained, have many other care tasks and do not always understand the usefulness of data collection (as no feedback of information is provided) (Lewin et al., 2009a), motivation for data collection is often low, which undermines the quality of data (Fretheim et al., 2009b). In order to draw data from different sources and store information in a way accessible for various users, HIS should be integrated and strengthened with sufficient capacity at all levels to produce, analyse and use information (Kimaro et al., 2008). Moreover, all actors (e.g. MoH, donors and Civil Society Organisations (CSOs)) should standardly use these strengthened HIS (World Bank et al., 2008).

Two core requirements of HIS strengthening are: (i) a focus on the improvement of the entire health information and statistical system and not only those related to specific diseases and (ii) a concentration on strengthening country leadership for the production and use of health information (Health Metrics Network, 2008). In 2005 the World Health Organisation (WHO) initiated the Health Metrics Network (HMN) with the intention to assist low and low-middle income countries in meeting these two requirements through the 'Framework and Standards for Country Health Information Systems' (i.e. the HMN Framework). The objectives of the HMN Framework are to focus investment and technical assistance on standardizing HIS development and to permit access to and better use of improved health information at country and global levels (Health Metrics Network, 2008).

As the HMN framework is supposed to function as “the universally accepted standard for guiding the collection, reporting and use of health information by all developing countries and global agencies'” (Health Metrics Network, 2008: v) it is important to pay attention to this framework in the context of this study. The HMN framework describes six components of a health information system, subdivided into inputs, processes and outputs. The input component encompasses 'health information system resources' and refers to coordination and leadership, information policies and financial and human resources. The three process components are 'indicators', 'data sources' and 'data management'. Indicators are necessary to assess changes in the determinants of health (socioeconomic and demographic factors, environmental and behavioural risk factors), health systems (inputs, outputs and outcomes) and health status (mortality, morbidity and well-being) (Health Metrics Network, 2008). Factors which need to be taken into account when selecting indicators include validity, acceptability,

feasibility, reliability, sensitivity to change and predictive validity[7] (Fretheim et al., 2009b). Data sources in the health sector mainly include surveys, birth and death registration, census, health facility reporting systems and surveillance and administrative systems (Chan et al., 2010). Strong data management is necessary to ensure data of good quality, which meet some criteria including timeliness, periodicity, consistency, representativeness and disaggregation (Health Metrics Network, 2008). The last two components of a health information system are related to outputs: 'information products' and 'dissemination and use', meaning that data should be compiled, managed and analysed to become information which can subsequently be used for decision-making (Health Metrics Network, 2008). In order for information to be used, however, a well-functioning health information system is not sufficient. For this end the second requirement of health information systems strengthening, i.e. country leadership, is essential. This is e.g. illustrated by the case of Malawi. Even though Malawi's health information system is considered as one of the best in Africa (Chaulagai et al., 2005), information from this system has been so far hardly used for decision-making, due to amongst others a lack of skills, resources, leadership and incentives (Chaulagai et al., 2005).

Even if a HIS is strengthened, it is not automatically institutionalised within the Ministry of Health, which is necessary for future sustainability. A sustainable HIS is integrated in the daily work of the Ministry of Health and is flexible enough to adjust to changing user needs (Kimaro and Nhampossa, 2005). It aligns various interests of MoH, software developers and donors (Kimaro and Nhampossa, 2005) and local data collectors and users should participate in its design (Kimaro and Nhampossa, 2005; Piotti et al., 2006). Supervision should be increased and used as effective support instead of reprimand (Piotti et al., 2006). Supervisions which are rather educational visits targeted at the identification of obstacles to change are seen as the most efficient ones (Fretheim et al., 2009a). Both Kimaro and Nhampossa (2005) and Piotti et al. (2006) advocate for the use of a cultivation approach, which implies gradual changes on the basis of existent technology and network of users.

3.2. Joint Sector Reviews

An M&E instrument which is increasingly used within the SWAp context is a joint sector review (JSR), which is a forum to assess progress, resolve issues and reach agreements on the sector program (World Bank, 2001; Overseas Development Institute and Mokoro, 2010) and which should replace the evaluation of individual projects (Peters and Chao, 1998). While there is so far no standardised definition, a JSR could be described as "a type of joint periodic assessment of performance in a specific sector with the aim to satisfy donor and recipient's accountability and learning needs" (Holvoet and Inberg, 2009: 205). 'Performance' is to be interpreted broadly and may include a focus on substance at various levels (i.e. inputs, activities, output, outcome and impact) and on underlying, systemic and institutional issues. JSRs are most common in the health and education sector.

[7] Validity is "the extent to which the indicator accurately measures what it purports to measure"; acceptability is "the extent to which the indicator is acceptable to those who are being assessed and those undertaking the assessment"; feasibility is "the extent to which valid, reliable and consistent data are available for collection"; reliability is "the extent to which there is minimal measurement error, or the extent to which findings are reproducible should they be collected again by another organisation"; sensitivity to change is "the extent to which the indicator has the ability to detect changes in the unit of measurement"; predictive validity" is the extent to which the indicator has the ability to accurately predict relevant outcomes" (Fretheim et al., 2009: 3).

In most countries JSRs are organised once or twice a year and engage a broad range of state and non-state stakeholders who are spread over several working groups which focus on specific topics, including quantity and quality of outputs and outcomes, public finance management, human resources and management information systems. The most important input in the JSR is often the sector performance report, prepared by the sector ministry and including financial reporting from the sector finance department or Ministry of Finance. Information from the sector performance report is sometimes combined with additional in-depth studies on specific topics, surveys and diagnostic studies (e.g. Public Expenditure Reviews, Public Expenditure Tracking Surveys, Value for Money and Service Delivery Surveys, see Overseas Development Institute and Mokoro, 2010) as well as information from 'project' donors or civil society organisations active in the sector (Holvoet and Inberg, 2009). In some countries field missions are included in the JSRs. Evidence from the different sources subsequently feeds into several working groups for discussion. Conclusions and recommendations from these discussions are usually shared with stakeholders at the Annual Review Meeting. The main documentary output of the JSR is the aide-émoire, which is signed by the government and donors (Holvoet and Inberg, 2009).

In practice many JSRs witness several weaknesses, including (i) an emphasis on being joint instead of an emphasis on being independent and based on verifiable information, (ii) biased selection of review team members, (iii) hastily written mission reports and aide-mémoires resulting in insufficient check and review of information (Brown et al., 2001), (iv) weak sector performance reports due to incompleteness (Brown et al., 2001), lack of routine data on service delivery, lack of results orientation and weak link to sector expenditure (Overseas Development Institute and Mokoro, 2010) and (v) limited follow-up of recommendations formulated in the aide-mémoires (Martinez, 2006; Overseas Development Institute and Mokoro, 2010). Moreover, a review of JSRs in the education sectors in Burkina Faso, Mali and Niger (Holvoet and Inberg, 2009) highlighted that the JSRs are mainly focused on substance (mainly sector activities and outputs), while institutional and systemic issues (i.e. the underlying processes) are largely neglected. This is understandable in the short run as stakeholders are primarily interested in sector 'substance' results. Failing to invest in systemic issues, however, runs counter to the increased awareness of the importance of institutional capacity for the successful implementation of SWAps and the sustainable achievement of sector outcomes and impact in the long run (see Cassels, 1997). In spite of these country findings, JSRs have, in principle, the potential to function as M&E exercises that reconcile short and longer term objectives, at least if they make room for M&E system strengthening in the short run. While this necessitates additional investments, it may also lead to more donor alignment with recipient M&E systems and less laborious complementary M&E exercises in the long run. It may as well generate a gradually evolving outlook of a JSR; from an assessment of 'substance' to a monitoring and assessment of the quality of sector M&E systems, their main outputs as well as their actual degrees of feedback and usage (i.e. a kind of meta-evaluation instrument[8]) (Holvoet and Inberg, 2009). In a similar vein, a recent WHO report refers to JSRs as the key entry point to assess progress and performance of the M&E system (World Health Organisation, 2009). JSRs could not only contribute to the realisation of key principles of 'results-orientation' and 'alignment' but also to the improvement of mutual accountability by concurrently assessing

[8] A meta-evaluation is "a systematic review of evaluations to determine the quality of their processes and findings" (Leeuw and Cooksy, 2005: 95).

donor performance against Paris Declaration targets, including the transparency and predictability of donor funding (Walford, 2007), as is done for example in Mozambique (Boesen and Dietvorst, 2007).

4. NIGER: GENERAL BACKGROUND

Niger, a landlocked country in West-Africa, is one of the poorest countries in the world. Niger's economy is largely agrarian and subsistence-based. According to See et al. (2010) Niger faces all four poverty traps which Collier identified in The Bottom Billion (2007) to explain why some countries do not develop: i) internal conflicts and risks of conflicts, ii) land-locked and dependent on neighbouring countries, iii) Dutch disease[9] and iv) bad governance. However, the growth outside the agrarian sector has been strong and Niger's economy has been largely saved from economic and financial international turbulences (Ambassade de Belgique au Niger, 2010). Since February 2010 authority in Niger has been exercised by a transitional government, which took power through a military coup. Elections have been promised but a date has not been fixed so far (Central Intelligence Agency, 2011).

The decentralisation process was consolidated with the first municipal elections in July 2004, which resulted in the establishment of 265 councils (Republic of Niger, 2007), of which 213 rural and 52 urban (See et al., 2010). These councils are grouped into 36 departments and seven regions (See et al., 2010). Problems with the decentralisation process include inadequate financial resources, lack of transformation of national policies and strategies into local ones (Republic of Niger, 2007), illiteracy and lack of capacity of the new councils (Republic of Niger, 2007; See et al., 2010).

Since 1990 Niger has been ranked among the countries with the lowest human development index (HDI): 1/130[10] in 1990 (UNDP, 1990), 174/174 in 1995 (UNDP, 1995), 173/174 in 2000 (UNDP, 2000), 177/177 in 2005 (UNDP, 2005) and 167/169 in 2010 (UNDP, 2010)[11]. The HDI value in 2010 was 0.261, Niger's values for the sub-indicators are presented and compared with Sub-Sahara Africa (SSA) average in table 4.1.

Tabel 1. Scores on the sub-indicators of the HDI[12]

Sub-indicator	Niger	SSA
Life expectancy at birth (2010)	52.5	52.7
Mean years of schooling (2010)	1.4	4.5
Expected years of schooling (2010)	4.3	9.0
Gross National Income (GNI) per capita (PPP 2008 $) (2010)	675	2,050

Source: UNDP, 2010

The GNI per capita rank minus the HDI rank stands at -3, which means that compared to countries with a similar level of GNI per capita, Niger is not effective in translating its growth into human development.

[9] Dutch disease refers to the situation in which natural resources are managed in an unclear way by only a few people who do not share profits (See et al., 2010).
[10] In 1990 the country with the lowest human development was ranked first, the country with highest human development last.
[11] In comparison: Sierra Leone which has been 'a concurrent' of Niger for many years (e.g. 173/174 in 1995, 174/174 in 2000 and 176/177 in 2005) has accomplished to climb to 158/169 in 2010.
[12] In the 2010 Human Development Report, 'adult literacy rate' has been replaced by 'years of schooling', 'gross enrolment rate' has been replaced by 'years of schooling that a child can expect to receive given current enrolment rates' and Gross Domestic Product (GDP) per capita has been replaced by Gross National Income (GNI) (UNDP, 2010: 15).

As of 2010 the Human Development Report replaces the Gender-related Development Index (GDI) and the Gender Empowerment Measure (GEM) with the Gender Inequality Index (GII), which measures "loss in achievements due to gender disparities in the dimensions of reproductive health, empowerment and labour force participation" (UNDP, 2010: 26). The values range from 0, perfect equality, to 1, total inequality. Niger's GII is, with a value of 0.807 (Sub-Saharan Average is 0.735), ranking among the countries with the highest inequality (136/138). The values for GII's sub-indicators for Niger and Sub-Saharan Average are shown in table 4.2.

Table 2. Scores on the sub-indicators of the Gender inequality index

Sub-indicator		Niger	SSA
Maternal mortality rate (2003-2008)		1800	881
Adolescent fertility rate (1990-2008)		157.4	122.3
Seats in parliament (%) (2008)	F	12.4	17.3
Population with at least secondary education	F	2.5	23.9
(% ages 25 and older) (2010)	M	7.6	38.1
Labour force participation rate (%) (2008)	F	37.9	63.8
	M	88.1	82.3

Source: UNDP, 2010

4.1. Policy cycle

Niger elaborated its second Poverty Reduction Strategy Paper (PRSP), the Accelerated Development and Poverty Reduction Strategy 2008-2012 (ADPRS), in 2007. The vision of the ADPRS is to become "an emerging country, founded on a dynamic, diversified and sustainable economy, harmoniously distributed on the national territory, a modern, civil, democratic and well-governed republic, a nation rich in its culture and shared values, a society open to the world and attached to knowledge and technological innovation, free from corruption and poverty, a nation that is prosperous, equitable, and respectful of ethics, united, peaceful and committed to African integration" (Republic of Niger, 2007: 75). The ADPRS takes into account the Millennium Development Goals (MDGs) and strategies formulated by the African Union, the Community of Sahel-Saharan States (CEN-SAD), the Economic Community of West African States (ECOWAS) and the West African Economic and Monetary Union (WAEMU)[13] (Republic of Niger, 2007: 76).

The ADPRS, through which Niger intends to attain 14 main targets by 2012[14], consists of seven pillars:

[13] ECOWAS and WAEMU formulated a Regional Poverty Reduction Strategy (RPRS) in 2006 with the aim (i) to offer regional organisations a strategic framework within which they can enhance prioritisation of regional programs and better combine them with national programs to maximise the impact of growth and poverty reduction; (ii) to provide member states with enhanced visibility of all regional programs, which can then be factored into the preparation of their national strategies; (iii) to provide partners with a strategic framework developed by all member countries, that will enhance the organisation of external assistance to the countries and to the integration process in order to maximize the efficiency of such assistance (ECOWAS and WAEMU, 2006: 32).

[14] An annual economic growth rate of at least 7%; a poverty rate of 42% for individuals; a malnutrition rate (underweight) of 24%; a gross primary education enrolment rate of 94%; an adult literacy rate of 45% ensuring gender parity; a child mortality rate of 108‰; a maternal mortality rate of 200 for 100,000 life

- A strong, diversified, sustainable and job-creating growth;
- Equitable access to quality social services;
- Control of population growth;
- Reduction of inequalities and strengthening of social security of the vulnerable groups;
- Infrastructure development;
- Promotion of good governance;
- Effective implementation of the strategy (Republic of Niger, 2007).

In order to optimise resource allocation, priorities should be ranked (See et al., 2010), but no such efforts are made within the ADPRS.

Niger obtains a score 'moderate' on indicator 1 of the Paris Declaration (PD) "number of countries with national development strategies (including PRSs) that have clear strategic priorities linked to a medium-term expenditure framework and reflected in annual budgets" (OECD/DAC, 2005: 9). The scores of indicator 1 (and 11, see §1.1.2.) are based on the Comprehensive Development Framework (CDF) reports of which the last update of 2007 indicates that 'action is taken' (A) with regard to Niger's progress on this indicator, which means that "progress is being made, although not yet enough, and the basis exists for even substantive progress" (World Bank, 2007: xii). On the three sub-indicators, 'unified strategic framework', 'prioritization' and 'strategic link to the budget' Niger scores an A as well (World Bank, 2007) (see annex 2 for the guidelines used to score progress). The Niger country chapter of the 2008 PD survey identifies the improvement of links to the budget as the major challenge. A priority action is therefore to adopt a global Medium Term Expenditure Framework (MTEF) and to apply sector MTEFs (OECD/DAC, 2008b: 40-1). See et al. (2010) highlight that without the implementation of this priority action Niger will not be able to improve its score on indicator 1.

Several institutes are involved in the implementation, monitoring and evaluation (M&E) of the ADPRS. Table 4.3. provides an overview of these institutes and their responsibilities.

births; HIV/AIDS prevalence rate kept below 0.7%; a drinking water access rate of 80%; increase the electricity access rate to 3% in rural areas and 46% in urban areas; a 35% utilization rate of impregnated mosquito nets for children and pregnant women; a total fertility rate of 6 children per woman; area of protected lands at least equal to 8% of the national territory; 110% coverage of national cereal requirements (Republic of Niger, 2007: 76/77).

Table 3. Institutes involved in the implementation and M&E of the ADPRS

Institute	Responsibilities
National Steering Committee (chair: Prime Minister and Head of Government)	- To set the policy and strategic orientations of the ADPRS; - To ensure compliance with ADPRS priorities in budget programming; - To assess the effects of its implementation on economic and social development.
National Committee of government and technical and financial partners (chair: minister in charge of finance)	- To promote the coordination and harmonisation of interventions by different actors; - To facilitate financial and technical resource mobilisation; - To ensure the alignment of budgetary assistance; - To validate the report on monitoring aid coordination.
National Technical Committee (chair: coordinator PRS / Permanent Secretariat PS)	- To promote synergy between the different sectors; - To draft, implement, monitor and evaluate sector-wide plans of action and reforms; - To approve the action monitoring reports drafted by the sector committees; - To ensure the consolidation of the ADPRS participatory approach and ensuring that the ADPRS/PS has the required technical capacities for coordinating its activities; - To promote ownership of the ADPRS by all players at sector level; - To coordinate the organisation of ADPRS review and revision exercises; - To report to the National Steering Committee and maintaining operational relations with the other bodies in charge of ADPRS monitoring and evaluation; - To validate and monitor the annual development policies, programmes and projects evaluation programme.
Sector Committees (chair: technical officials from the sector)	- To draw up reports on the implementation of the different sector policies and programmes; - To ensure that sector policies are consistent with the ADPRS and that projects and programmes are consistent with policy.
Committee for Consulting and Dialogue (chair: the Secretary General in charge of community development)	- To ensure the active participation of civil society agents in the process of drafting, implementing, and monitoring and evaluating the ADPRS; - To ensure the inclusion of aspirations of civil society in the drafting and implementation of the ADPRS.
Regional Steering Committees (chair: governors)	- To plan, monitor and evaluate activities in the region; - To define the annual programmes and to provide an annual regional ADPRS monitoring report; - To serve as a forum for consultation and information, bringing together all regional actors.
Departments Steering Committees (chair: prefects)	- To plan, monitor and evaluate activities in the department; - To define the annual programmes and providing an annual departmental ADPRS monitoring report; - To serve as a forum for consultation and information, bringing together all sub-regional actors.

PRS/PS	- To coordinate the ADPRS preparation process and to monitor its implementation; - To carry out regular reviews of the strategy; - To ensure the circulation of information on outcomes both horizontally (to all the units involved), and vertically (from the central to the decentralized levels); - To serve as the secretariat of the committees at central level in relation with the sector bodies; - To provide technical support to the committees at the decentralised level; - To ensure that information is used to improve the design and implementation of the ADPRS; - To act as a relay for monitoring the Regional Poverty Reduction Strategy of WAEMU and ECOWAS.

Source: Republic of Niger, 2007: 116/117

Besides these institutes, communal Monitoring Committees will gradually be set up in each commune and new supervisory structures for the rural areas will be created (Republic of Niger, 2007: 117).

Drawing upon a Public Expenditure Management and Financial Accountability Review (PEMFAR), an action plan was approved in June 2005 with the aim to improve the financial management of the state and other public establishments (Bauer et al., 2008). According to the 2008 Paris Declaration (PD) survey, Niger has a moderately strong public financial management (PFM) system (score 3.5 out of 6 on indicator 2a in the 2006 and 2008 PD survey) (OECD/DAC, 2008b: 40-4). However, an evaluation of the PFM system (using the Public Expenditure and Financial Accountability (PEFA) method) in 2008 highlighted that the budget is not credible, the translation of national policy into the budget is in an embryonic state and the amount of direct budget support of donors is insufficiently known at the moment the budget is presented and even at the beginning of execution (Bauer et al., 2008). Since 2006 a reform programme is in place to improve procurement systems, resulting in a B score (on a four point A-D scale) on indicator 2b in the 2008 PD Survey (OECD/DAC, 2008b: 40-4).

Like many other institutions and organisations in Africa (AfCoP, 2010), Niger's government aims at putting Management for Development Results (MfDR) into practice and to establish units responsible for planning and evaluation within the different ministries (CAP-Scan Team, 2009). Even though African institutions and organisations encounter different challenges in strengthening MdDR resources, some common patterns can be identified including the necessity to build capacities in the public sector, the need for political will and use enough time to adopt result-based management approaches (AfCoP, 2010). To assess and build MfDR capacity, Niger's government, with the support of the United Nations Development Programme (UNDP), implemented an MfDR Capacity Scan (CAP-Scan) in 2009 (CAP-Scan Team, 2009). A CAP-Scan is "a short-term, broad-based, low-cost and high-level diagnostic review to identify and prioritize needs in the five central pillars of MfDR: Leadership, Accountability and Partnerships, Monitoring and Evaluation, Planning and Budgeting, and Statistics" (***http://www.mfdr.org/CAP-Scan.html***). Of the five MfDR pillars, Niger decided to focus on the leadership, M&E and planning and budgeting pillars. Priority dimensions include 'responsibility and delegation at the level of senior officials of the administration', 'integration of the

decentralisation dimension', 'human resource management' (leadership pillar), 'system for measuring user satisfaction', 'administration performance geared to development results' (M&E pillar) and budget preparation based on objectives and results (planning and budgeting pillar) (CAP-Scan Team, 2009:7). With the last priority dimension Niger also aims at facing the challenge formulated in the 2008 PD survey (see above).

Monitoring and evaluation

While evaluation practice has been increasing in Niger, the quality of evaluations is often insufficient due to poor monitoring (See et al., 2010). Niger scores weak on PD indicator 11. The overall score in the last CDF update, on which the PD score is based, is an E (elements exist), which means that "there is some basis for making progress, either through what already exists, or definite plans" (World Bank, 2007: xii). On the sub-indicators 'quality of development information' and 'stakeholders access to information' Niger scores an E as well, on the sub-indicator 'coordinated country-level M&E' an A (action taken) (World Bank, 2007) (see annex 3 for the guidelines used to score progress). Only the education and the health sector have a performance evaluation framework in place and use performance information in their annual activities programme (OECD/DAC, 2008b: 40-13). The health sector has the best knowledge as far as results are concerned (See et al., 2010). Monitoring instruments for general and other sector strategies are either not established or not yet implemented and the Directorates for Studies and Programming (DEP: Direction des Études et de la Planification) in most ministries are not well-equipped and hardly have incentives to monitor (See et al., 2010: 113). The major challenge with regard to the managing for results principle is the generation of evaluation mechanisms. A priority action formulated in the 2008 PD survey is strengthening statistical capacity and results-based budgeting (OECD/DAC, 2008b: 40-1).

Compared to the first PRSP, the ADPRS gives a greater role to the management of action plans and M&E (Republic of Niger, 2007: 76). Intentions for the establishment of a results-based M&E system are elaborated in the ADPRS under the 'Effective implementation of the strategy' pillar (Republic of Niger, 2007: 113-117). The ADPRS M&E system will be based on results-based management principles and will allow to "(i) monitor programme and project implementation; (ii) assess the effects and living standards of households; and (iii) assess the impact of development policies and programmes" (Republic of Niger, 2007: 113).

Niger's government intends to formulate an Evaluation Development Policy with the aim to "improve the supply and demand of evaluation by improving evaluation practices, promoting evaluation, and strengthening the human, material, and institutional capacities involved" (Republic of Niger, 2007: 114). Within this framework a capacity building programme will be implemented which will focus on e.g. the improvement of the organisational and institutional environment, the increase of human and financial resources, the definition of standards and methodologies and the publication of M&E reports (Republic of Niger, 2007: 114).

In order to inform decision-making, the M&E system will provide several documents:

- annual results based monitoring report (prepared by the PRS/PS)
- national development projects and programmes monitoring report (on the basis of projects and programmes monitoring at sector level)

- impact assessment reports: mid-term review in 2010, final review in 2012, evaluation of sector policies, ex-ante assessments of project and programmes of donors
- table of ADPRS M&E indicators (updated and refined on the basis of criteria related to availability, reliability and relevance (Republic of Niger, 2007: 114).

A communication plan will be implemented with the aim to promote information sharing, awareness, participation and ownership of the ADPRS process by all actors and to identify the information requirements of and most appropriate format for different users (Republic of Niger, 2007: 115).

During the final workshop of the CAP-Scan an overall self-assessment of MfDR capacities, on the basis of sector self-assessments, has been formulated. The M&E pillar was assessed on six dimensions, of which the scores and conclusion are presented in table 4.4. The total score was 1.96 (out of 4) (CAP-Scan Team, 2009).

Table 4. Scores on dimensions of the CAP-Scan M&E pillar

Dimension	Score	Conclusion
National planning geared to development results	3.00	Clearly, a monitoring and evaluation practice has been launched, particularly in the framework of the ADPRS. However, that practice must be strengthened by ensuring the operation of the units concerned and the standardisation of the tools used.
Capacity for monitoring and evaluation of public policies	2.50	The units have been set up but the capacities need to be strengthened. A program to that effect is in the process of becoming operational.
Information system and decision-support tools	2.00	Information tools and systems exist but are not integrated into a comprehensive data processing scheme, including adequate interconnections for ensuring information accuracy and consistency.
System for measuring user satisfaction	1.25	The need for quality service is acknowledged but measuring the quality in question is so far a rare practice.
Administration performance geared to development results	1.00	Department management is still focused on resources and activities, without actually addressing performance.
Harmonisation of information requests by donors	2.00	There is ongoing dialogue on reporting format standardisation but no uniform rules or approach are available, as of yet.

Source: CAP-Scan Team, 2009: 51-54

As the dimensions ‘system for measuring user satisfaction’ and ‘administration performance geared to development’ have the lowest scores, it is obvious why these have been chosen as priority within the M&E pillar (see §4.1).

National Statistics System

The National Statistics System consists of the National Institute of Statistics (INS: Institut National de la Statistique) and statistics departments at sector level (République du Niger, 2008a: 9), which will be strengthened under the ADPRS in order to collect, use and publish on a regular basis all relevant information (Republic of Niger, 2007). The system still needs to be decentralised to meet the ADPRS requirements in poverty monitoring (Republic of Niger, 2007).The INS was created by law (la loi N°2004-01) in 2004 with the aim to organise the production, the analyses, the editing, the dissemination and use of statistics. The law regulates the scientific independence in the production and dissemination of statistics, but also refers to the obligation of primary data suppliers and questionnaire respondents to be neutral, objective, impartial and anonymous (République du Niger, 2008a: 9).

In 2007 a National Strategy for the Development of Statistics (SNDS: Stratégie Nationale de Développement de la Statistique) had been elaborated by the Permanent Technical Secretariat of the SNDS with technical and financial support of e.g. the European Union, the African Development Bank, the African Capacity Building Foundation, the UNDP and the Partnership in Statistics for Development in the 21st Century (PARIS21) (République du Niger, 2008a: 2). The SNDS aims to strengthen the statistical system with sufficient means (human, financial, equipments) in order to contribute to the design, monitoring and evaluation of economic and social development policies, programmes and projects, including in particular the ADPRS and the MDGs (République du Niger, 2008a: 11).

In the CAP-Scan the 'statistical data processing' pillar got the highest score: 2.50/4. The scores and conclusions for the six dimensions are presented in the table below.

Table 5. Scores on dimensions of the CAP-Scan statistical data processing pillar

Dimension	Score	Conclusion
Statistics strategy and plan	3.25	The mechanisms are in place but the system is still young, pending full operational preparation for the SNDS
Data disaggregation	3.00	Although not yet uniform over all sectors, disaggregation is a common practice. In some cases, more detailed disaggregation is necessary for effective use of data in decision-making.
Extent of data	2.50	The scope of statistical data now extends beyond the small number of priority sectors but does not yet ensure full coverage commensurate with national planning.
Data quality assessment	2.00	The practice of data validation is not yet comprehensive but is expected to be generalized through the INS approval procedure.
Capacity for conducting and exploiting country-wide surveys	2.25	Surveys are carried out regularly on a trans-sector basis. However, the filing of survey results is not yet systematic and there is room for enhancing data dissemination and analysis.
Capacity for analysis and modelling	2.00	Despite some modelling examples, analysis and modelling capabilities are still limited. There is no specific plan for developing such capabilities.

Source: CAP-Scan Team, 2009: 59-61

4.2. Development aid

Niger received 605 million USD net Official Development Aid (ODA) in 2008, an increase of 16.8% compared to 2006. The net ODA/GNI was 11.3% in 2008. The largest donors were the European Commission (EC), followed by France and the World Bank. Belgium was the tenth largest donor with 19 million USD in 2007-08 (average) (OECD and World Bank, s.a.).

In order to agree on the allocation of International Development Aid (IDA) among eligible countries, the World Bank created the IDA Resource Allocation Index (IRAI), which is based on the Country Policy and Institutional Assessment (CPIA). The IRAI consists of sixteen variables which are distributed among four clusters. Scores range from 1, lowest, to 6, highest. Niger scored 3.3 on the IRAI 2009 (rank = 43/77). Niger's scores for the four clusters are: 'economic management': 3.8; 'structural policies': 3.3; 'policies for social inclusion/ equity': 3.1 and 'public sector management and institutions': 3.1 (***http://siteresources.worldbank.org/IDA/Resources/73153-1181752621336/IRAI2009table1.pdf***). As Niger has a score above 2.5, it is eligible for budgetary aid (Ambassade de Belgique au Niger, 2010). Given the fact that the transition government is improving its governance capacities, the Belgian Embassy in Niger expects the next IRAI score to improve (Ambassade de Belgique au Niger, 2010: 9).

The Ministry of Finances and Economy is responsible for the global coordination of aid. The mechanisms for coordination and monitoring include the evaluations and annual programming of the State Investment Programme and joint reviews. In the context of the Paris Declaration and the implementation of the ADRSP new mechanisms and coordination instruments have been installed by the government. The implementation of the United Nations Development Assistance Framework (UNDAF) also requires consultation amongst all stakeholders (Organisation Mondiale de la Santé, 2009: 13).

At policy level a Government - donor commission is responsible for the coordination and harmonisation of donors' interventions and functions as a dialogue framework between the government and donors. It also ensures alignment of support to the budgetary cycle and facilitates the mobilisation of financial and technical resources (Organisation Mondiale de la Santé, 2009: 13). At technical level the Comité Technique Inter Agences (CTIA) is responsible for the coordination of the preparation of the PRSP, the monitoring of its implementation and for regular revisions (Organisation Mondiale de la Santé, 2009: 13).

A consultation framework between the Government of Niger and donors involved in public finances (EC, World Bank, International Monetary Fund (IMF), France and UNDP) was signed in March 2008 (Ambassade de Belgique au Niger, 2010: 12), with the intention to facilitate the implementation and monitoring of the action plan of the PEMFAR (OECD/DAC, 2008: 40-4). Belgium is an observer during these consultations. Since the appointment of a new Minister of Economy and Finances, the dialogue on public finances between donors and the government has been improved and is presently, according to the Belgian embassy, honest and constructive (Ambassade de Belgique au Niger, 2010: 12).

Between 2005 and 2007 donors in Niger did not make much progress on the PD alignment and harmonisation indicators as table 4.6. demonstrates. The scores, however, disguise major differences among donors; for example Belgium coordinated 100% of its

technical co-operation (indicator 4) in 2007, while France decreased its coordination from 21% to 0% between 2005 and 2007 (See et al., 2010).

Table 6. summary table of donor related indicators in the PD monitoring survey

Indicators	2005	2007	2010 Target
Alignment			
3. Aid flows are aligned on national priorities	99%	91%	100
4. Strengthen capacity by co-ordinated support	15%	50%	50%
5a. Use of country PFM systems	27%	26%	51%
5b. Use of country procurement systems	49%	37%	N.A.
6. Strengthen capacity by avoiding Parallel PIUs	52	47	17
7. Aid is more predictable	73%	78%	87%
8. Aid is untied	84%	84%	>84%
Harmonisation			
9. Use of common arrangements or procedures	31%	49%	66%
10a. Joint missions	21%	18%	40%
10b. Joint country analytic work	40%	32%	66%

Source: OECD/DAC, 2008

In their joint evaluation of the cooperation of the European Commission, Belgium, Denmark, France and Luxembourg with Niger between 2000-2008, See et al. (2010: 63), remark that it is quite easy for donors to align themselves with Niger's strategies, as the content is largely determined by themselves (in particular by the World Bank and the UNDP). Challenges formulated in the 2008 PD monitoring survey with regard to the alignment and harmonisation principles are donors' continuous use of parallel units and the limitation of common procedures to the health and education sector respectively. Priority actions for the two principles are strengthening capacity and transparency as well as centralising information on donors' activities (OECD/DAC, 2008b: 40-1).

According to See et al. (2010) donors in Niger offered aid without development in the period 2000-2008 and failed to draw any conclusions from this situation. They point at the fact that aid can consist of relevant and effective interventions which are, however, unable to increase the economic growth, that is an enabling condition for sustainability. Factors contributing to a lack of sustainability include insufficient aid volume, the limited duration of projects and the limited assets on which the country can base economic growth as a result of which aid can hardly be used as a catalyst and becomes rather a source of income in itself (See et al., 2010). As the prospect of sustainability is very distant, See et al. conclude that the donors included in the evaluation "should therefore not place too much emphasis on sustainability, and not sacrifice immediate effectiveness at the altar of sustainability for the upcoming decade" (See et al., 2010: 89).

5. NIGER'S HEALTH SECTOR

Niger's health indicators are below the minimal international norms, which is amongst other factors due to a weak educational level, poverty, malnutrition, minimal access to drinking water (Organisation Mondiale de la Santé, 2009: 3), harmful childcare practices (see Hampshire et al., 2009) and limited referrals from health centres to district hospitals of young children in particular (see Bossyns et al., 2006). Table 5.1. presents scores on some health-related Millennium Development Goal (MDG) indicators for Niger as well as the African average.

Table 7. Performance of Niger and average of Africa on the health-related MDG indicators (for which a regional average is available)

Indicators (a)	Niger	Africa average
Under-five mortality rate (per 1000 live births), 2008	167	142
Measles immunization coverage among 1-year-olds (%), 2008	80	73
Maternal mortality (per 100,000 live births), 2005	1800	900
Births attended by skilled health personnel (%)	18	47
Contraceptive prevalence (%)	11.2	23.7
Adolescent fertility rate (per 1000 girls aged 15-19 years)	199	118
Antenatal care coverage (%): at least 1 visit	46	73
Unmet need for family planning (%)	15.8	24.3
Prevalence of HIV among adults aged 15-49 years (%), 2007	0.8	4.9
Males aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (%)	16	30
Females aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (%)	13	23
Antiretroviral therapy coverage among people with advanced HIV infection (%) 2007 (b)	10	44
Malaria mortality rate (per 100,000 population), 2006	229	104
Children aged <5 years sleeping under insecticide-treated nets (%)	7	17
Tuberculosis mortality rate among HIV-negative people (per 100,000 population), 2008	37	51
Population using improved drinking-water sources (%), 2008	48	61
Population using improved sanitation (%), 2008	9	34

Source: World Health Organisation, 2010
(a) For the indicators for which no specific year is given, the WHO report mentions 'the latest available data since 2000'
(b) The regional average is based on 2008 updated data

As the table demonstrates Niger scores very weak on some important impact indicators, such as the under-five mortality rate (which is due to diseases and acute respiratory infections in combination with severe malnutrition, see Lapidus et al., 2009), the maternal

mortality rate (twice the African average) and malaria mortality rate and on outcome indicators related to preventive measures, such as children aged <5 years sleeping under insecticide-treated nets, population using improved drinking water sources and population using improved sanitation.

Several political, socioeconomic and cultural factors worsen the management, the availability and use of health services, including the poor condition of roads reducing the accessibility of certain villages to vaccination activities; the weak schooling rate of girls and alphabetisation rate of the general population; the weak incomes of the majority of the population; the recent insecurity in some parts of the country; and seasonal migration of labourers to neighbouring countries (République du Niger, 2009: 24).

Over the past few years, and within the framework of the second Health Development Plan (PDS: Plan de Développement Sanitaire) for the period 2005-2010, a number of important reforms were initiated. These include the development of a Sector Wide Approach (SWAp) (see §5.3.1.) and the introduction of free care for pregnant women and children under five-years (République du Niger, 2010: 73/74), which had started as an intervention of a German non-governmental organisation (HELP) in two regions in 2006 (Ridde and Diarra, 2009). A process evaluation of this initiative demonstrated the necessity to integrate the modalities for fees abolition in all levels of the health system, instead of introducing it as a parallel system, a lesson which HELP has used in its support to Niger's government in implementing the new national policy (Ridde and Diarra, 2009).

According to the basic note of the Belgian embassy in Niger the implementation of the PDS 2005-2010 resulted in acceptable levels of some health indicators in 2009, including amongst others the percentage of prenatal visits (90%), the percentage of use of curative cure (43.5%) and the percentage of contraceptive use (16.5%) (Ambassade de Belgique au Niger, 2010: 6).

5.1 Health Policy and Health Sector Strategic Plan

In 2002 Niger approved a National Health Policy for the period 2002-2011, in which strategic orientations for the development of the health sector are defined. In order to implement the health policy the PDS 2005-2010 was elaborated (Organisation Mondiale de la Santé, 2009: 4).

In January 2010 the Ministry of Health (MSP: Ministère de la Santé Publique) started with the elaboration of a new PDS for the period 2011-2015 (Ambassade de Belgique au Niger, 2010: 6), using a results- (and gender-) based management approach and a participative and multi sector approach, involving all stakeholders (e.g. service providers, donors, connected sectors, civil society and private sector) (République du Niger, 2010: 20). However, the public (both patients and citizens), are not specifically mentioned as stakeholders whereas their engagement might be helpful in designing a policy that is focused on their specific concerns, which will eventually lead to better policy implementation, better health services and even better health (Oxman et al., 2009d). The PDS elaboration process included the elaboration of strategic orientations, in which a problem tree was used to identify the causality of problems and to formulate objectives. This resulted in the formulation of a logical framework, the selection of

indicators and identification of targets (République du Niger, 2010: 21). The mid-review of the PDS 2005-2010 indicated that the PDS was too directive and too detailed, with not much space for decision and action for the operational structures. As a result, the PDS 2011-2015 is a more strategically oriented document, defining the principal objectives which should be achieved in five years as well as strategic axes to reach these objectives. It is up to the operational structures to define operational objectives, strategies and activities (Ambassade de Belgique au Niger, 2010: 13).

Even though the objectives of the PDS 2005-2010 were more realistic than those of the Accelerated Development and Poverty Reduction Strategy (ADPRS) and MDGs, they will probably not be achieved (See et al., 2010). It is more likely that the general objective of the PDS 2011-2015 will be realised because it is vaguely formulated in terms of mortality and morbidity reduction, especially among the vulnerable groups, and focused on the achievement of the health MDGs (République du Niger, 2010: 39). However, the specific objectives, including the reduction of under-five mortality from 198 ‰ in 2006 to 114 ‰ in 2015 and the reduction of maternal mortality from 648/ 100 000 in 2006 to 405/100 000 in 2015[15] seem to be quite ambitious. This is similar to many sector policies, which, according to Boesen and Dietvorst (2007), incline to be too ambitious in view of past performance and available capacity and resources.

The PDS formulates 13 general results to be achieved, including among others a functioning monitoring and evaluation (M&E) system, the implementation of approaches to improve the quality of care, the inclusion of a gender dimension in all health actions and the establishment of a functional health research framework (République du Niger, 2010: 41). The PDS will be implemented through eight priority axes, including:

- Extension of health coverage;
- Development of qualitative reproductive health services;
- Equipment of health structure with competent and motivated human resources in accordance with needs;
- Permanent availability of medicines, vaccines, dietary and therapeutic inputs, reactives, blood and derivatives;
- Intensification of the fight against diseases which are object of integral surveillance in Niger;
- Strengthening of governance and leadership at all health system levels;
- Development of financing mechanism of the health sector;
- Promotion of health research (République du Niger, 2010: 43).

According to Cassels (1997: 36), a policy framework within the SWAp context should include, besides sector goals and objectives, a definition of the roles of the public, private and voluntary sector in the financing and provision of health care, an identification of policy instruments and institutional arrangements and a guidance for expenditure prioritisation (of both government and donors). While policy instruments and institutional arrangements are described in the PDS 2011-2015, the roles of the public, private and voluntary sectors are not

[15] The other specific objectives are to invert the actual tendency in HIV/AIDS, malaria and tuberculosis evolution and to strengthen the fight against diseases which are the object of integral surveillance in Niger (République du Niger, 2010: 41).

defined, neither is guidance included for expenditure prioritisation. A highly similar conclusion was drawn as far as the ADPRS is concerned (see §3.1.).

Every year the MSP prepares an action plan which takes into account the work plans of the executive entities at central, regional and district level. These action plans are one of the inputs for the joint sector reviews (JSRs). Comments of participants at the JSRs are taken into account in the last version which is submitted to Parliament. The corresponding budget is based on the financing needs of the action plan, taking into account the amounts available in MSP's budget and donor's contribution (Le Gouvernement du Niger et les bailleurs, s.a.: 2/3). Since 2007 each health district formulates a health development plan conform the orientations of the PDS, which are translated for each region in a regional health development plan (République du Niger, 2008b: 6).

5.2. Health systems

The health system consists of three types of actors: public sector, private sector and traditional health care (République du Niger, 2010: 26). The majority of the population rely on traditional health care (Organisation Mondiale de la Santé, 2009: 3). The private sector is especially oriented towards curative activities and is developed in parallel to the national health development policy (République du Niger, 2008b: 7).

The public health system is organised in three administrative and care levels: central, intermediary and peripheral. The table below gives an overview of the actors within these levels as well as their functions.

Table 8. the function and actors in the public health system

Administrative level	Function	Administrative structures	Care structures
Central	Design, monitoring and evaluation of policies and strategies	Health ministry, general divisions (2) and central divisions (15)	National hospital (3) Specialised centres (6) Schools/ institutes (3)
Intermediary	Technical support	Regional departments of public health (DRSP: Direction Régionale de la Santé Publique) (8)	Regional hospital centres (6) Dentistry cabinets (1)
Peripheral	Operationalisation of policies and strategies	Health districts (42)	District hospitals (24) Health centres (2509, of which 2049 functional)

Source: République du Niger, 2008b and Ambassade de Belgique au Niger, 2010

At village level there are health posts which are managed by community-based workers, who are hardly supervised. The health centres at district level are managed by a nurse and supervised by a community-based management committee (Ridde and Diarra, 2008).

Major weaknesses in Niger's health system are related to the lack of involvement of the population in making health-related decisions, the lack of intersectoral collaboration, inadequate financial protection of users, and the lack of results-based management and human resource management (Ambassade de Belgique au Niger, 2010: 14). In order to tackle shortcomings, Niger elaborated a document for the strengthening of its health system, which will be financed by the World Bank and the common fund of Niger's health sector (République du Niger, 2009:10).

In the context of the health system strengthening (HSS) program of the Global Alliance for Vaccines and Immunisation (GAVI), a specially created working group, presided by the Director of Public Hygiene and Health Education, wrote a proposal for support (République du Niger, 2009), which was approved on the 29th of July (***www.gavialliance.org***). The aim of GAVI's HSS programme is to contribute to the improvement of the health situation of the population in general and the one of mother and child in particular (République du Niger, 2009: 29). One of the specific objectives is to support the elaboration and adoption of the new PDS 2011-2015 (République du Niger, 2009: 29).

Health Information System

An important element within the health system is the health information system, referred to as the SNIS (Système National d'Information Sanitaires), which produces the necessary information for the monitoring of the epidemiological situation, the coverage, the accessibility and the use of services, and the human, material and financial management (République du Niger, 2008a: 37). The SNIS is represented at the different levels of the health system. At the lowest (village) level, staff members of the health centres collect the information, at district level, the data are centralised by the 'Centre de Surveillance Epidémiologique' and at regional level by the 'Service de la Programmation et de l'Information Sanitaire' (République du Niger, 2006: 34).

The SNIS has many institutional and operational weaknesses, including e.g. the non-inclusion of activities of certain hospitals and the private sector; difficulties related to the analyses and processing of data at peripheral level; difficulties related to the harmonisation of definitions, concepts and monitoring indicators; weaknesses in the production, diffusion and conservation of data; and insufficient supervision at all levels (République du Niger, 2008a: 38). Some of these weaknesses are addressed in the PDS 2011-2015, which includes the improvement of the SNIS within the governance and leadership strategic axis[16]. Specific objectives related to the SNIS are to assure the permanent availability of qualitative health information for decision-making at all levels and to carry out at least 90% of the anticipated supervisions at all levels (République du Niger, 2010: 67). The focus on supervision is positive, as this could be an effective means to realise changes (see Piotti et al., 2006 and § 3.1.). Strengthening of supervision and coaching is also included in the priority interventions and in the results indicators (% of realized supervision at all levels) (République du Niger, 2010).

[16] It is remarkable that the title of the paragraph describing the improvement of the SNIS is 'the improvement of the M&E system' with SNIS put between parentheses, as if SNIS correspond with the M&E system.

The strengthening of the SNIS is included as well in e.g. the GAVI proposal and in the cooperation strategy of the World Health Organisation (WHO)[17].

5.3. Health financing

Niger's health sector is financed by internal and external as well as public and private sources. The most important sources of finance are the state, local communities, households, the health insurance system, donors, the national social security fund and the private sector (République du Niger et Organisation Mondiale de la Santé, 2005: 30). In 2003, 33.66% of the financing was provided by households, 38.54% by the state, 25.8% by donors, 0.64% by local communities and 1.36% by Non-Governmental Organisations (NGOs) (République du Niger et Organisation Mondiale de la Santé, 2005: 18). Notwithstanding the high poverty incidence among Niger's population, the share of households' contribution to national health expenditures increased to 43.65% in 2006 (République du Niger, 2010: 33). In 2008 the contribution of the local communities and the private sector was 2%, while decentralisation-related documents refer to a minimum of 8% of local communities' budget which should be spent on health (République du Niger, 2009: 33).

In 2010 the national budget for the health sector was 7.85%, which is a decrease compared to previous years (9.63% in 2009, 10.17% in 2008 and 9.54% in 2007) (République du Niger, 2010: 34) and significantly below the 15% which African leaders agreed upon in Abuja, Nigeria, in 2001 (République du Niger, 2009: 26) and the 10% recommended by the WHO (République du Niger et Organisation Mondiale de la Santé, 2005: 35). Health expenses per capita were about 17 USD in 2006, which is half the amount that is considered necessary for essential health interventions (34 USD according the WHO) (République du Niger, 2010: 32).

The PDS 2011-2015 formulates some major obstacles in the health financing, including:

- A chronic underfinancing;
- The preponderance of households in the financing of global health expenses, despite the high poverty incidence and extreme vulnerability of the population;
- The quasi-inexistence of social protection systems;
- The dependency on extern financing (51% in 2007);
- The weak mobilisation of available funds and timely production of documentary evidence hamper the efficient and effective use of financial resources at the disposal of the MSP and decentralized services (République du Niger, 2010: 32/33).

The total costs for PDS financing are estimated to be 2.2 billion USD[18], which is on average 400 million USD per year. An overview of the financial needs per strategic axis is presented in the table below.

[17] The WHO document refers to HMN, but Niger is not listed on the HMN website among the countries receiving HMN support.
[18] 1.097 billion FCFA: exchange rate of August 2010 (month of draft version PDS)

Table 9. total financial needs per axis (in million USD)

Strategic axis	Financial needs 2011-2015	%
Health covering	169	7.7
Reproductive health	677	30.9
Human resources	248	11.3
Medicines and other inputs	493	22.5
Fight against diseases	477	21.7
Governance and leadership	125	5.7
Financial mechanisms	1	0.1
Health research	4	0.2
Total	**2,195**	**100**

Source: République du Niger, 2010: 16

The elaboration of a Medium Term Expenditure Framework (MTEF) will be linked with a country agreement to assure the engagement of both government and donors in the financing of the new PDS (République du Niger, 2010: 37).

Donors in the health sector

In line with many other aid-dependent countries (Boesen and Dietvorst, 2007) the government of Niger is more focused on donor coordination than on domestic sector coordination. In 2005 12 donors signed a partner framework with the MSP, which defines the general cooperation and consultation framework between the MSP and donors. It demonstrates the willingness of the signatories to support the implementation of the PDS within the framework of a harmonised execution and monitoring of interventions, including sector reviews, external evaluations, joint field missions, technical and financial execution report of the PDS and monthly consultation meetings (Ambassade du Belgique en Niger, 2010: 14/15). Boesen and Dietvorst (2007) highlight that while donor coordination is important, it should be viewed from a wider perspective and come only after domestic coordination. The Belgian aid agency, as lead donor, stimulates the partner framework, coordinates dissemination of information and organises the consultation between donors and MSP. In 2007 donors and MSP decided to experiment with regional lead donors with the aim to strengthen the coordination and the complementary of interventions at de-concentrated level (Ambassade du Belgique en Niger, 2010: 15). The joint evaluation of the cooperation of the European Commission, Belgium, Denmark, France and Luxembourg with Niger between 2000-2008 (See et al., 2010) refers to the health sector dialogue between donors and the ministry of health as being active and focused on priorities defined by the government, including the decentralised level. According to the authors “there is thus a shift from interventions that were centred on a sanitation problem in a specific geographic zone to a true programme approach at national level” (See et al., 2010: 74). According to the basic note of the Belgian Embassy (2010) the dialogue has been improved since the transition authorities took power. The basic note is however more critical on the efforts made by some donors to share information or to participate in evaluation planning meetings organised by the MSP. The Belgian Embassy refers to the fact that some donors are rather timid during discussions with the MSP and still limit themselves to the implementation of their own interventions instead of investing in the strengthening of actors who implement the SWAp.

Moreover, donors hardly react on documents provided by the MSP and the lead donor. It also seems that many donors still have limited capacity to support the elaboration of policies, plans and strategies as well as their implementation, monitoring and evaluation (Ambassade du Belgique en Niger, 2010: 17).

In 2006 the World Bank and the French aid agency (AFD: Agence Francaise de Développement) signed an agreement letter with the MSP with the intention to install and execute a common basket fund (FC: Fonds Commun) to finance the implementation of the PDS. The World Bank committed 35 million USD for the period 2006-2011 and the AFD 18 million USD. Since June 2010 Spain has contributed to the FC as well and Belgium is in the process of getting approval for FC contribution (a basic note for the allocation of budgetary aid to the FC to support the PDS has been finalised in September 2010) (Ambassade du Belgique en Niger, 2010: 5). The FC, which has the aim to temporally solve in a harmonised and joint way the weaknesses of the national procedures, is a step forward compared to the situation before with many parallel projects, as it is integrated in the planning of the sector. Moreover, the responsibility of the national partner has been increased (Ambassade du Belgique en Niger, 2010). Nevertheless, according to the MSP the FC will only become a real sector financing tool if the United Nations organisations and the Global Fund to fight Aids, Tuberculosis and Malaria (GFATM) join it (See et al., 2010).

6. ASSESSMENT OF THE HEALTH SECTOR'S M&E SYSTEM

In this chapter Niger's health sector's monitoring and evaluation (M&E) system will be assessed on six criteria including i) policy, ii) methodology, iii) organisation, iv) capacity, v) participation of actors outside government and vi) use of information. In doing so a five-point scoring system is used: weak (1), partially satisfactory (2), satisfactory (3), good (4) and excellent (5). Documents used for this assessment include the Health Development Plan 2011-2015 (PDS), the M&E guide for the PDS 2005-2010, the National Strategy for the Development of Statistics (SNDS), the proposition for support of the Global Alliance for Vaccines and Immunisation (GAVI), the Accelerated Development and Poverty Reduction Strategy (ADPRS) 2008-2012 and the basic note of the Belgian embassy in Niger.

Table 6.1. shows that the 'methodology' and 'participation of actors outside government' criteria score best with a 'satisfactory' score while the 'use of information' criterion scores worst with a 'weak' score. The different sections in chapter six further substantiate the quantitative assessment with more qualitative and detailed information on each of the M&E key areas, while annex 4 provides the scores for each of the 34 sub-indicators.

Table 10. assessment of the health sector's M&E system

Criteria	Score
Policy	2
Methodology	3
Organisation: structure	2
Organisation: linkages	2
Capacity	2
Participation of actors outside government	3
Use of information	1

6.1. Policy

In order to assess the quality of Niger's M&E policy in the health sector, five issues were taken into account, including the existence of an M&E plan, the acknowledgement of the differences and relations between monitoring and evaluation, the acknowledgement of the need to be autonomous and impartial (which is particularly important for the accountability function of M&E), the approach to reporting, dissemination and integration and the integration of M&E results into planning and budgeting.

While autonomy and impartiality issues are included in the African Evaluation Guidelines[19], particularly within the propriety guidelines (AfrEA, 2002), none of the Niger health

[19] The African Evaluation Guidelines are based on the Program Evaluation Standards of the Joint Committee on Standards for Educational Evaluation (1994) and are formulated around four categories: utility, feasibility, propriety and accuracy. The Nigerien Network of Monitoring and Evaluation (ReNSE) was involved in the formulation of the guidelines (AfrEA, 2002).

documents refer to these issues, neither to the integration of M&E results into planning and budgeting.

Niger's health sector has an M&E policy, or an M&E guide, which was elaborated for the health development plan (PDS) 2005-2010. It aims to provide all necessary elements for the implementation and good functioning of the system and to set out the technical and methodological principles necessary for the management of the PDS (République du Niger, 2006: 4). For the PDS 2011-2015 the Ministry of Health's (MSP) study and planning department will elaborate a new M&E guide, which will include results indicators per level (République du Niger, 2010: 82). The present M&E guide provides plenty of information on the M&E organs and structures and presents the indicators to be measured. It is clear what to monitor, but not exactly what to evaluate (besides "the PDS itself"). The PDS 2011-2015 provides more specific information on what to evaluate in the final evaluation, including the obtained results, the impact of PDS and the level of attainment of the Millennium Development Goals (MDGs).

While the M&E guide indirectly indicates through its formulation of the role of M&E (to organise the collection, analyses, processing and diffusion of information, to identify problems, to alert the steering commission of the PDS and to propose corrective measurements) *why* to monitor and evaluate, it does not specify *how* to monitor and evaluate and *for whom*. Where the M&E guide refers to both monitoring and evaluation in the description of its role, the PDS 2011-2015 uses almost the same formulation, but with the important difference that the definition is restricted to monitoring only (République du Niger, 2010: 95). One might conclude that the people who elaborated the new PDS are more aware of the differences and relationship between monitoring and evaluation without however explicitly highlighting these in the PDS.

Both the M&E guide and the PDS 2011-2015 pay specific attention to the evaluation of the PDS. For the PDS 2011-2015 a midterm and a final evaluation are foreseen in 2013 and 2015 respectively. The midterm evaluation will consist of an internal and an external evaluation, the final evaluation will consist of an external evaluation and a beneficiary satisfaction survey (its results will be an input to the external evaluation) (République du Niger, 2010: 96).

The M&E guide is clear on the approach to reporting and dissemination: an overview is presented (see table 6.2.) of the reports which should be produced at the different levels and the channels which should be used to communicate results towards the public.

Table 11. M&E reports and communication channels at different levels

Level	Reports	Communication channels
National	- M&E reports - Minutes of meetings	- Meetings - Internet - Courier - Information bulletin - Annual statistics - Reportage - Conferences / debates
Regional	- M&E reports - Minutes of meetings	- Meetings - Internet - Courier - Information bulletin - Radio
Health districts	- M&E reports - Minutes of meetings	- Courier - Information bulletin - Meetings - Radio - Internet
Community	- M&E reports - Minutes of meetings	- Courier - Radio - Meetings - Internet
Health centres	- M&E reports - Minutes of meetings	- Courier - Radio - Meetings

Source: République du Niger, 2006: 18

As is clear from table 6.2., the MSP uses a mix of communication channels at all levels. It uses internet which offers opportunities to engage many people, but which has as a major disadvantage its limited access for poor people, as well as radio, which is the most important mass media in poor countries (Oxman et al., 2009d).

6.2 Methodology

The assessment of the methodology criterion includes the assessment of indicators (quality, disaggregation, selection criteria, priority setting and their integration into a causal chain), the methodologies used and the data collection.

The PDS 2011-2015 does not include a separate list of indicators, but the logical framework, in which the general objective (long term result), the four specific objectives (intermediate results) and the 13 expected results (immediate results) (see §2.1.) are specified, does include indicators. A list of key indicators, on which the M&E of the PDS will be based, still has to be determined (République du Niger, 2010: 95). Criteria for the selection of these indicators are not provided. Usually, the selection of criteria should take into account a number of factors, including validity, acceptability, feasibility, reliability, sensitivity of change and

predictive validity (see Fretheim et al., 2009b). While the M&E guide neither includes selection criteria which were used to select the 45 indicators for the PDS 2005-2010, it explicitly mentions that only the most pertinent indicators were selected for each level. Priority is set in order to be more efficient by reducing the workload for data collection in the field and to refrain from overburdening the monitoring system at the different levels (République du Niger, 2006: 21). Of the 45 indicators only 23 are selected for the allocation of the common basket fund (FC) (République du Niger, 2006: 21).

For all indicators included in the PDS logical framework a baseline and a target for 2015 are identified and most of them are formulated in a SMART (specific, measurable, achievable, regularly measured and time bound) way (see section 3). Even though no specific distinction is made between input, output, outcome and impact indicators, for all objectives and expected results one or more indicators are defined, as a result of which the different levels of indicators can be deducted. However, as the expected results are not linked with the specific objectives, the exact causality chain is not entirely clear.

In order to find out if specific problems are widespread or rather related to specific groups or regions (Lavis et al., 2009c) data should be disaggregated. A 2002 study of the Canadian International Development Agency (CIDA) amongst others referred to the need to disaggregate indicators in order to better understand urban-rural and gender disparities in Niger (Canadian International Development Agency, 2002). It seems that in general data disaggregation has improved as the 2009 CAP Scan (see §4.1.1.) highlights that disaggregation has become common practice while it simultaneously also indicates the need for further disaggregation in some sectors. As far as the health sector is concerned, indicators are still not disaggregated enough by sex, region or socio-economic status. This is also recognised in the PDS which states that the disaggregation of data, in particular along lines of sex, remains to be strengthened (République du Niger, 2010: 36).

As far as data collection is concerned, the logical framework specifies for each indicator the source of verification. In the M&E guide related to the former PDS, a table is included which describes for each selected indicator the institute/agency responsible for data collection, the method of collection (routinely through the SNIS (see §5.2.1.) or through a survey[20]), the data collection source (e.g. health information system (SNIS) reports, national budget, collection fiche) and the frequency of collection. One can expect that the same kind of table will be included in the new M&E guide.

In sharp contrast to the details provided on data collection, no specific information is given on methodologies for monitoring and particularly evaluation.

[20] Indicators for which a survey is necessary include: maternal mortality rate, infant/youth mortality rate, contraceptive prevalence rate, percentage of children of 24-59 months suffering from growth delay, prevalence de HIV/AIDS rate, percentage of service users which are satisfied with the provision of services and percentage of children under five who sleep under a simple or impregnated mosquito net.

6.3. Organisation

6.3.1 Structure

The organisation-structure indicator focuses on the coordination and oversight structure, the existence and functioning of joint sector reviews and sector working groups, the level of ownership and the use of incentives. However, within the context of this desk study no information on sector working groups, the level of ownership and the use of incentives was found in the documents. Even though the Niger documents are country owned and do contain information on M&E and intentions to strengthen the M&E system, it is not clear to which extent the content of these documents has been influenced by the donors. It is important in this regard to recall the observation of See et al. (2010), who highlighted that donors have a major influence on Niger's policies (see §4.2.), and the support of GAVI in the elaboration and adoption of the new PDS 2011-2015 (see §5.2.[21]).

With regard to coordination and oversight, at each level of the health system two types of M&E bureaus are active. Firstly, decision-making bureaus (the health committees), which are responsible for giving orientations, assessing the results and deciding on the assignment of human, material and budgetary resources, and secondly technical bureaus (the technical committee)[22], which are responsible for the execution and daily management as well as the M&E of the PDS. The health committees at the community and health centre level meet every trimester, the health committees at the higher levels each semester. The technical committees meet every month at health centre level, every trimester at district level and every semester at regional and national level (République du Niger, 2006: 5).

The National Health Committee (CNS: Comité National de Santé), which is presided by the Minister of Health, has been functional since November 2006 and is in charge of the relation and coordination between the government and donors involved in the health sector. In order to facilitate the elaboration of sector policy documents and the M&E guide the National Technical Health Committee (CTNS: Comité technique National de Santé) was created in December 2006. The CTNS is led by the General Secretary of the MSP and is composed of representatives of different MSP structures and levels, of other ministries, of the private sector, of civil society organisations and of donors (Républic du Niger, 2009: 11).

Concerning the technical structure at central level, four units within MSP have a central role in the M&E of the PDS, including:

- the General Secretariat of the MSP
- the department of studies and planning (DEP: Direction des Etudes et de la Planification), including the M&E comity
- the Department of Financial Affairs (DAF: Direction des Affaires Financieres))
- the Department of Statistics (DS: Direction des Statistique)

Table 6.3. provides an overview of the responsibilities of each unit.

[21] One of the activities related to this specific objective is the recruitment of a national and international technical assistant to support the elaboration of the PDS 2011-2015 (République du Niger, 2009: 31).
[22] At community level there is only a health committee.

Table 12. responsibilities of the units involved in M&E

Unit	Responsibilities
General Secretariat of the MSP	- To prepare CNS meetings; - To monitor the implementation of CNS's decisions; - To mediate between the CNS and the regional health committees.
DEP	- To prepare the general annual M&E plan; - To participate in the selection of key indicators, the elaboration of tools and data collection plan; - To install a financial management system which cut across the financial data and the activities with the financing sources of the annual action plans; - To participate in the elaboration of quarterly and annual reports for the MSP, donors and other partners; - To evaluate the data collection process and data analysis by linking activities with disbursement.
DAF	- To watch over the adequacy of presented budgets of the costs centres with the initial and actual budget allocation; - To assure the monitoring of the immobilisation and management of stocks; - To monitor the budgetary registration operations and the availability of funds; - To prepare periodical financial reports of management centers (quarterly, annual and cumulative); - To accomplish of obligations and payments to management centers.
DS	- To monitor the data collection for the analysis of the health situation of the country; - To verify the quality of collected data; - To analyse of data on each level of the health system in order to be able to make adjusted decisions; - To assure information feedback at all levels; - To assure the management of the data bank for different structures of the MSP and its partners; - To assure the epidemiological surveillance.

Source: République du Niger, 2006: 11-13

Within the 75 days after the end of each semester, the General Secretariat organises, in accordance with the manuals, a joint sector review (JSR) for which the donors, the executive entities of every level, other representatives of the government, members of the CNS and other stakeholders in the execution of the PDS are invited (République du Niger, 2006: 11).

The objective of these joint reviews is to provide information in a harmonised way and to review the progress of the PDS, the use of funds (through the financial monitoring report) and the planning of activities and their financing in the subsequent period (République du Niger, 2006: 11). Fifteen days before the joint reviews at central level, joint reviews at the regional level take place, which again takes place seven days after the second and the fourth trimester monitoring at district level. The joint reviews are preceded by field missions (République du Niger, 2006: 39) in order to prepare the JSR and to feed discussions with information collected in the field (Ambassade du Belgique en Niger, 2010: 18). At the end of the JSR an aide-mémoire is formulated and approved by the participants (le Gouvernement du Niger and les

bailleurs, s.a.: 2), which includes recommendations and directions for the route to be followed between two reviews. In practice, however, these recommendations are not always observed (Ambassade du Belgique en Niger, 2010: 18).

As we did not have the opportunity to analyse the content of the aide-mémoires (or participate in a JSR), we are not able to provide information on the quality of the JSRs in Niger's health sector. Even though the quality of JSRs in the health sector is not automatically comparable with the quality of JSRs in the education sector (as this is e.g. dependent on the quality of the sector information systems and the capacity of responsible persons within sector ministries and donor organisations) it is still interesting in this context to refer to an assessment of the JSRs in Niger's education sector (see Holvoet and Inberg, 2009). This assessment demonstrated that the education JSRs are strongly oriented towards accountability at the activity level. They mainly focus on education access and quality dimensions but gradually also devote more attention to institutional development. This evolution in focus is mainly due to the increasing awareness that weak improvements in health 'substance' are to a large extent due to a lack of improvements in the quality of underlying systems.

6.3.2. Linkages

The organisation-linkages indicator assesses the existence of linkages between sector M&E and the statistical office, between different M&E units in sub-sectors and the central health M&E unit (horizontal integration), between the health sector M&E unit and the central (PRSP) M&E unit (vertical upward integration), between the health sector M&E unit and health M&E at decentralised levels (vertical downward integration). It also explores to what extent M&E of donor health projects is integrated within the national health sector M&E system. A CIDA diagnostic study of the PRS M&E system in Niger (among others) concluded that linkages between the different parts of the national statistics system were underdeveloped (Canadian International Development Agency, 2002). While the PDS (2011-2015) refers to the existence of an institutional plan which links the health sector M&E with the INS and which needs to be reviewed, more details on the plan itself are not provided. The SNDS includes information on the health information system (SNIS) and highlights several weaknesses (see §5.2.1.). One of the weaknesses concerns the weak institutional position of SNIS as a new statistics department which has not been operational yet (République du Niger, 2008a).

As far as the link between the sector M&E unit with M&E units in different sub-sectors and semi-governmental institution is concerned (horizontal integration), the information at hand only highlights that the private sector, the health service of the army and the association of traditional medicines are represented in the CNS (see §6.3.1.). When it comes to the linkages between the sector M&E unit and the central M&E unit (vertical upward integration), it is interesting to highlight that in the health documents no references are made to the national M&E system or e.g. the PRSP secretariat. There is no mentioning of joint reviews at central level, which are normally also (at least partly) based upon input from joint sector reviews. More information is available regarding the vertical downward integration. At all levels (health centre, community, district, regional and national) health committees and technical committees are installed and their responsibilities and composition are described in the M&E guide. The lower levels are also represented in the committees of the higher levels, e.g. the regional health directors CTNS and the presidents of the regional health committees are member of the CNS. Moreover, reports of the joint reviews at district level feed into the joint reviews at regional level

whose reports feed into the central joint reviews. All regional departments of public health (DRSP) participate in the central joint reviews (République du Niger, 2006: 39). The regions and the districts elaborate their own scorecards, which are inspired by the national model, but which take regional and district realities into account (République du Niger, 2009: 33).

However, while the integration with decentralised levels is realised on paper, it is not clear how these committees work in practice. It is relevant in this respect to mention the critical observations included in the proposition for GAVI support which refers to (i) a partition of central departments which hampers the communication between different departments at central level and between the MSP and other levels of the health system and to (ii) an insufficient decentralisation with regard to human resources (République du Niger, 2009: 24).

While donor projects are not specifically mentioned, one of the responsibilities of the CNS is the coordination of donors' actions (République du Niger, 2006: 9). It is not clear from the documents if this includes coordination of donors' M&E as well.

6.4. Capacity

The questions related to the capacity indicator focus on the existing M&E capacity, the acknowledgement of problems and the existence of an M&E capacity building plan.

While the monitoring and evaluation capacities used to be very weak (Canadian International Development Agency, 2002), in the past few years, and more particularly within the framework of the PDS and the ASDRP, the M&E system has been revitalised. The elaboration of the M&E guide has led to the introduction of a consultation framework, including the CNS and the CTNS, which made it possible to validate the administrative and routine data, to plan and realise periodic surveys and to interpret the results during periodic meetings (République du Niger, 2009: 49).

The PDS only refers to specific SNIS problems, including the exclusion of private sector data and the need to improve the quality of data and its permanent availability at all levels (République du Niger, 2010: 35/36). In a similar vein, the proposal for GAVI-support also refers to weaknesses at the level of the quality and availability of data and mentions further that data analysis, formative supervision and communication at peripheral level need to be improved (République du Niger, 2009: 49).

While a specific capacity plan to deal with the weaknesses in the health sector M&E system does not exist, the PDS and the M&E guide refer to the need to strengthen capacities and include capacity-strengthening activities. In the PDS two specific capacity-strengthening interventions are included: strengthening the capacities of individual actors to use tools for the collection, the processing, the analysis and the management of data and strengthening the technical and logistical capacities of structures responsible for the management of health information (equipment, packaged software for the data processing) (République du Niger, 2010: 68).

In the 2006 M&E guide the organisation of two different kinds of training workshops were indicated as being necessary prior to the installation of an effective M&E system: i) a

training workshop for district management staff and central supervisory staff with the aim to acquire knowledge on M&E mechanisms at all levels and to reinforce auto-evaluation and ii) a training workshop in every health district on micro planning with the aim to facilitate the elaboration, the implementation and the evaluation of micro plans. It is not clear on the basis of the information at hand whether these workshops have effectively taken place. Besides these workshops, there is also training and M&E capacity building which is organised through the WHO which provides amongst others tools and experts to the Health Ministry (Organisation Mondiale de la Santé, 2009: 23).

6.5. Participation of actors outside government

This 'participation of actors outside government' indicator focuses on the participation of parliament, civil society and donors in the health sector's M&E. While there is an increasing acknowledgement of the importance of involving non-state actors and parliaments in policy formulation, implementation and M&E (Boesen and Dietvorst, 2007), the Niger health documents hardly refer to the participation of parliament and civil society. They only highlight the representation of the National Assembly in the CNS and the representation of CSOs in the health committees at all levels as well as their participation in the JSRs. No references are made to the Nigerien Network of Monitoring and Evaluation (ReNSE), which was involved in the formulation of the African Evaluation Guidelines.

More information is provided on the participation of donors, which is not entirely surprising as, according to See et al. (2010), donors in Niger generally control M&E efforts, even if evaluations are done jointly with the government. The 2005 M&E guide indicates that donors will participate actively in the M&E of the PDS (République du Niger, 2006). The JSR is the main M&E mechanism for donors, while monthly consultations allow the MSP and the donors to maintain a continuous dialogue and exchange of information and have a general reflection on current events in the period between different JSRs (Ambassade du Belgique en Niger, 2010: 18). Besides participating in the JSRs, donors are represented in the CTNS at central level and in the health committees at all levels, except at primary health care centre level (République du Niger, 2006: 5). In the CNS and the CTNS the lead donor in the health sector (Belgium) is the representative, but other donors participate as well in the CTNS (République du Niger, 2006: 9/10). The PDS 2011-2015 indicates that the functionality of the consultations with donors at central and regional level has to be strengthened by integrating this M&E process in the M&E processes of the PDS (République du Niger, 2010: 37).

6.6. Use of information

The questions related to the use of information indicator focus on the presentation of relevant M&E results and effective use of M&E by national actors at central and local level, by national actors outside government and by donors. Unfortunately, not much information is available to answer these questions, as no references are made in the health documents to information from the M&E system and no monitoring reports are available. The only thing that can be mentioned in this context is that all levels should produce M&E reports (see §6.1.). Positively, the PDS 2011-2015 presents at lot of data (without however mentioning the data source) and does efforts to analyse why certain objectives were or were not obtained.

7. CONCLUSION

Within the context of the 2005 Paris Declaration (PD) and the 2008 Accra Agenda for Action (AAA) partner countries have committed themselves to set up transparent and monitorable performance assessment frameworks, while donors have committed themselves to align themselves with these performance assessment frameworks and to collaborate with partner countries in order to strengthen the systems. Progress in this area is however slow: only three out of 54 countries surveyed in the PD Survey had adequate results-oriented frameworks. Donors, from their side, are reluctant to rely on systems which are only partially developed, which simultaneously blocks the further elaboration and maturing of recipient systems. Generally progress at sector level is stronger and particularly within health and education sectors where, in the context of Sector Wide Approaches (SWAps), several initiatives are taken to strengthen monitoring and evaluation (M&E) systems.

Before strengthening an M&E system it is important to assess the strengths and weaknesses of the existing system, taking both M&E supply and demand side into account. In this working paper the M&E system in the health sector of Niger is assessed on the basis of an adapted and extended version of the checklist of Holvoet and Renard (2007). The checklist consists of six criteria: i) policy, ii) methodology, iii) organisation (subdivided in iiia structure and iiib linkages), iv capacity, v) participation of actors outside government and vi) use of information. For the assessment a five-point rating scale was used. It is important to highlight that the assessment has so far only been based upon available secondary data. The picture needs to be complemented and nuanced by primary data collection on the ground.

The assessment shows that the M&E system in Niger's health sector is so far not yet well developed: none of the criteria obtains a score 'good' or 'excellent'. Only 'methodology' and 'participation of actors outside government' are considered 'satisfactorily', while 'policy', 'organisation' (both structure and linkages) and 'capacity' score 'partially satisfactory' and 'use of information' 'weak'. 'Policy' is considered 'partially satisfactory' because there is an M&E guide for the PDS 2005-2010 (a new M&E guide will be elaborated for the PDS 2011-2015), which provides information on the M&E organs and structures, the indicators to be monitored, the reports which should be produced at all levels, including as well the way to communicate findings to the public. However, the sector M&E policy is silent on the need to be autonomous and impartial, the need to integrate results from M&E into planning and budgeting is not highlighted and differences and relationships between monitoring and evaluation are not explicitly identified.

The M&E 'methodology' is considered 'satisfactory', but this score reveals large differences between the various sub-components. Selection of indicators is graded 'satisfactory' because indicators are included in the logical framework of the new health development plan (PDS) and while this PDS does not provide a list of all indicators such an overview is included in the M&E guide of the former PDS. Moreover, the indicators in the M&E guide are linked to the responsible agency, the method and frequency of data collection, resulting in an 'excellent' score (the only!) for the 'data collection' sub-indicator. Other elements which contributed positively to the relatively good score on 'methodology' are the quality of indicators (the indicators include a baseline and a target and are generally SMART), as well as the fact that the number of indicators is limited in order to be more efficient and not overburden the system. However, none of the documents provide information on the criteria used for the selection of

indicators or on the methodologies used for monitoring and evaluation. Moreover, and apparently contrary to other sectors (see CAP-Scan), indicators in the health sector are not disaggregated by region, sex or socio-economic data.

The score 'partially satisfactory' on both 'organisation' criteria (i.e. structure and linkages), also mask large differences between the grading of the different sub-components. This is particularly true as far as 'structure' is concerned. While the documents provide sufficient information regarding the institutional structure for coordination, support, oversight, analyses of data and feedback and describe extensively the mechanism of joint sector reviews as well as the responsibilities of the different units involved in M&E, no information is available on sector working groups, on ownership or on incentives used to stimulate data collection and use. As far as 'linkages' are concerned, there is a large difference between 'vertical upward integration' and 'vertical downward integration'. Whereas much information is available on the M&E structures at decentralised level and their representation at higher levels, no information is supplied on relations between the health sector M&E unit and the national M&E system, including the PRSP secretariat and joint reviews. Some information on the linkages with the statistical office, horizontal integration and links with M&E of donor projects is available, but not sufficient to get a complete picture. It is in particular regarding the organisation criteria that primary data collection might be extremely valuable to complement and nuance the assessment which is made on the basis of the scarcely available secondary data.

As far as capacity is concerned, documents highlight that there have been improvements over the years, but several capacity weaknesses still exist. Moreover, even though several capacity activities have been described, a specific capacity plan to deal with the weaknesses of the M&E system does not yet exist.

The relatively high score for the 'participation of actors outside government' criterion is especially due to the active participation of donors, who largely control M&E efforts and who are represented at all levels, except for the primary health care centre level. The M&E structure provided in the M&E guide shows that civil society organisations and parliament are represented in health committees, but no additional information on their participation is available. As no monitoring reports are available and no references are made in other documents to M&E outputs, the 'use of information' criterion is scored 'weak'.

Taking into account that Niger is one of the lowest developed countries in the world, with very weak scores on many health indicators, the assessment of the health sector M&E system is maybe more positive than expected. The active role of donors might possibly be related to the scores obtained. It is likely that donors have to a large extent influenced the PDS 2011-2015 as well as stimulated the elaboration of an M&E guide which sets out M&E policy and methodology. Primary data collection during a field mission might expose a more pessimistic reality. The fact that no monitoring reports, which are important outputs of the M&E system, are available for instance supports this line of reasoning. If M&E system strengthening is to a large extent pushed from the outside (donors) and not motivated through an internal M&E demand and supply side (both from within as well as outside government), it is likely that the outputs of the system as well as their use will be weak.

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ANNEX 1: CHECKLIST M&E SYSTEM AT SECTOR LEVEL

	Topics	Question
1. Policy		
1	M&E plan	Is there a comprehensive M&E plan, indicating what to evaluate, why, how, for whom?
2	M versus E	Is the difference and the relationship between M and E clearly spelled out?
3	Autonomy & impartiality (accountability)	Is the need for autonomy and impartiality explicitly mentioned? Does the M&E plan allow for tough issues to be analysed? Is there an independent budget?
4	Feedback	Is there an explicit and consistent approach to reporting, dissemination, integration?
5	Alignment planning & budgeting	Is there integration of M&E results in planning and budgeting?
2. Methodology		
6	Selection of indicators	Is it clear what to monitor and evaluate? Is there a list of indicators? Are sector indicators harmonised with the PRSP indicators?
7	Quality of indicators	Are indicators SMART (specific, measurable, achievable, relevant, time-bound)? Are baselines and targets attached?
8	Disaggregation	Are indicators disaggregated by sex, region, socio-economic status?
9	Selection criteria	Are the criteria for the selection of indicators clear? Is it clear who is involved in the selection?
10	Priority setting	Is the need acknowledged to set priorities and limit the number of indicators to be monitored?
11	Causality chain	Are different levels of indicators (input-output-outcome-impact) explicitly linked (program theory)? (vertical logic)
12	Methodologies used	Is it clear how to monitor and evaluate? Are methodologies well identified and mutually integrated?
13	Data collection	Are sources of data collection clearly identified? Are indicators linked to sources of data collection? (horizontal logic)
3a. Organisation: structure		
14	Coordination and oversight	Is there an appropriate institutional structure for coordination, support, oversight, analyses of data and feedback at the sector level? With different stakeholders? What is its location?
15	Joint Sector Review	Does the JSR cover accountability and learning needs for both substance and systemic issues? What is the place/linkage of the JSR within the sector M&E system? Does the JSR promote the reform agenda of the Paris Declaration?
16	Sector Working groups	Are sector working groups active in monitoring? Is their composition stable? Are various stakeholders represented?
17	Ownership	Does the demand for (strengthening of the) M&E system come from the sector ministry, a central ministry (e.g. ministry of planning or finance) or from external actors (e.g. donors)? Is there a highly placed 'champion' within the sector ministry who advocates for the (strengthening of the) M&E system?
18	Incentives	Are incentives (at central and local level) used to stimulate data collection and data use?

3b. Organisation: linkages		
19	Linkage with Statistical office	Is there a linkage between sector M&E and the statistical office? Is the role of the statistical office in sector M&E clear?
20	'Horizontal' integration	Are there M&E units in different sub-sectors and semi-governmental institutions? Are these properly linked to the sector's central unit?
21	'Vertical' upward integration	Is the sector M&E unit properly linked to the central M&E unit (PRS monitoring system)?
22	'Vertical' downward integration	Are there M&E units at decentralised levels and are these properly linked to the sector M&E unit?
23	Link with projects	Is there any effort to coordinate with donor M&E mechanism for projects and vertical funds in the sector?
4. Capacity		
24	Present capacity	What is the present capacity of the M&E unit at central sector level, sub-sector level and decentralised level (e.g. fte, skills, financial resources)?
25	Problem acknowledged	Are current weaknesses in the system identified?
26	Capacity building plan	Are there plans/activities for remediation? Do these include training, appropriate salaries, etc.?
5. Participation of actors outside government		
27	Parliament	Is the role of Parliament properly recognised, and is there alignment with Parliamentary control and oversight procedures? Does Parliament participate in Joint Sector Reviews and/ or sector working groups?
28	Civil Society	Is the role of civil society recognised? Are there clear procedures for the participation of civil society? Is the participation institutionally arranged or rather ad-hoc? Does civil society participate in Joint Sector Reviews and/ or sector working groups?
29	Donors	Is the role of donors recognised? Are there clear procedures for participation of donors? Do donors participate in Joint Sector Reviews and/ or sector working groups?
6. Use of M&E outputs		
30	M&E outputs	Is there a presentation of relevant M&E results? Are results compared to targets? Is there an analysis of discrepancies? Is the M&E output differentiated towards different audiences?
31	Effective use of M&E by donors	Are donors using the outputs of the sector M&E system for their information needs? Is the demand for M&E data from donors coordinated?
32	Effective use of M&E at central level	Are results of M&E activities used for internal purposes? Is it an instrument of policy-making and/or policy-influencing and advocacy at central level?
33	Effective use of M&E at local level	Are results of M&E activities used for internal purposes? Is it an instrument of policy-making and/or policy-influencing and advocacy at local level?
34	Effective use of M&E by outside government actors	Are results of M&E used as an instrument to hold government accountable?

ANNEX 2: ASSESSMENT CRITERIA USED TO SCORE PROGRESS TOWARDS OPERATIONAL DEVELOPMENT STRATEGIES

(www.oecd.org)

Score	Unified strategic framework	Prioritization	Strategic link to the budget
L	Government action is not guided by a long-term vision linked to a medium-term strategy, and there is little to no effort within the country to develop or update these strategic instruments.	There is little to no effort within the country to define long-term objectives and medium-term or short-term targets.	There has been little or no attempt to cost a medium-term strategy and link it to the budget, including through devising a medium-term fiscal framework.
E	A medium-term strategy is under preparation, but may not yet be derived from a long-term vision. Sector strategies are few, and may not yet be tied into a medium-term strategy. A strategic framework may be guiding short-term government action.	Initial efforts are underway to define holistic long-term objectives and prioritized medium-term or short-term targets.	There has been a preliminary attempt to cost a medium-term strategy and link it to the budget, including through initial efforts to prepare a medium-term fiscal framework.
A	There is a long-term vision and a medium-term strategy or strategies that may not be linked. Strategies in key sectors may not yet be integrated into national development strategy. The role of different strategy instruments in guiding policy is unproven, unclear, or provisional. Where they exist, efforts to align local with national strategy are preliminary.	There is a preliminary set or sets of specific long-term objectives and medium-term targets, and some prioritization of sequenced actions including attention to cross-cutting issues.	The medium-term strategy has been costed, linked to the medium-term fiscal framework and has some limited influence over the budget.
D	There is a long-term vision and medium-term strategy derived from the vision that is a reference point for policymakers, nationally, locally and at the sector level. Sector strategies and local development planning stem from the medium-term strategy and are sequenced with it.	The long-term vision and medium-term strategy identify objectives and targets linked to the MDGs but tailored, with some specificity, to country circumstances. The medium-term strategy focuses on a prioritized set of targets. It adequately addresses cross-cutting issues such as gender, HIV/AIDS, the environment, and governance.	A results framework is in place linking long-term goals to outcomes and outputs. The government is progressing toward performance-oriented budgeting to facilitate a link of the strategy with the medium-term fiscal framework and the budget, and helps focus capacity and resources at the national and local level on national objectives.
S	There are no warning signs of possible deterioration, and there is widespread expectation that the progress achieved is sustainable.		

ANNEX 3: ASSESSMENT CRITERIA USED TO SCORE PROGRESS TOWARDS DEVELOPING A RESULTS-ORIENTATED FRAMEWORK

Score	Quality of development information	Stakeholder access to information	Coordinated country-level monitoring and evaluation
L	Data collection is sporadic and outdated. Data have little relation to tracking the goals and targets in the long-term vision and medium-term strategy.	Little information on the long-term vision or medium-term strategy is available publicly, either in hard copy or electronically.	The government does not have a strategy or an action plan to develop a country-level M&E system. M&E is still largely fragmented, supported largely by external partners at the project level.
E	Data collection is improving but largely restricted to limited geographic or sectoral areas. Data may not cover key goals and targets in the long-term vision and medium-term strategy.	Some information on the long-term vision or medium-term strategy is available publicly, but may not be updated regularly or widely accessible.	The government has begun developing an M&E strategy and action plan to work toward the development of a country-level M&E system. M&E is still largely fragmented, supported largely by external partners at the project level.
A	Data collection has become more systematic and efforts to extend its geographic or sectoral scope are underway. Data are increasingly related to tracking goals and targets in the long-term vision and medium-term strategy.	Some information on the long-term vision or medium-term strategy and some public expenditure data are publicly available and regularly updated. Efforts may be underway to actively disseminate information.	A country-level M&E system has been at least preliminarily designed and its action plan is in the early stages of implementation but may be without fully coordinated support. The system is not yet functioning at all levels of government or sectors. There may be parallel country-level systems housed in different institutions.
D	Data are generally timely and comprehensive, and directly related to tracking the achievement of country goals and targets identified in the long-term vision and medium-term strategy. There is coordinated and systematic data gathering and analysis.	Information on the long-term vision and medium-term strategy, and progress in implementation, including public expenditure data, is made systematically available, including in local languages and through various media.	Implementation of an action plan for a country-level M&E system is well underway. This system tracks a manageable number of input, output and outcome indicators identified in the medium-term strategy, and produces unified reports used by country policymakers and external partners. Institutional responsibilities for M&E across government are clear.
S	There are no warning signs of possible deterioration, and there is widespread expectation that the progress achieved is sustainable.		

ANNEX 4: NIGER'S SCORE ON THE CHECKLIST FOR QUALITY ASSESSMENT OF AN M&E SYSTEM (HEALTH SECTOR)

1. Policy

	Topics	Score
1	M&E plan	3
2	M versus E	2
3	Autonomy & impartiality (accountability)	1
4	Feedback	4
5	Alignment of M&E with planning & budgeting	1

2. Methodology

	Topics	Score
6	Selection of indicators	3
7	Quality of indicators	4
8	Disaggregation	1
9	Selection criteria	1
10	Priority setting	4
11	Causality chain	3
12	Methodologies used	1
13	Data collection	5

3a. Organisation: structure

	Topics	Score
14	Coordination and oversight	3
15	Joint Sector Review	3
16	Sector Working groups	1
17	Ownership	1
18	Incentives	1

3b. Organisation: linkages

	Topics	Score
19	Linkage with Statistical office	2
20	'Horizontal' integration	2
21	'Vertical' upward integration	1
22	'Vertical' downward integration	4
23	Link with projects' M&E	2

4. Capacity

	Topics	Score
24	Actual capacity	2
25	Capacity problems acknowledged	2
26	Capacity building plan	2

5. Participation of actors outside government

	Topics	Score
27	Parliament	2
28	Civil Society	2
29	Donors	4

6. Use of information from M&E

	Topics	Score
30	M&E outputs	2
31	Effective use of M&E by donors	1
32	Effective use of M&E at central level	1
33	Effective use of M&E at local level	1
34	Effective use of M&E by outside government actors	1

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